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NOHIMS USERS' REFERENCE MANUAL
(COSTAR Operators Guide)

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16. Abstract (Limit: 200 words) The Computer Stored Ambulatory Record System (COSTAR) is one of the two sub-systems comprising NOHIMS. COSTAR is a medical information and communication system with software developed by Massachusetts General Hospital. COSTAR itself is a public domain software package which has been modified for use in Navy Occupational Medicine. The major modification being the elimination of accounts receivable and billing functions. COSTAR collects demographic and medical patient data both current and historical. Features of COSTAR include a variety of displays of a patient's medical records and the printing of various reports derived from individual patient records. The COSTAR Report Generator provides statistical data on medical records stored in the data banks. The report formats can be created for one time use or saved for standardized reports. COSTAR has the ability to store information which is timely, relevant and standardized. This information is immediately accessible. Special forms (i.e., SF 93, SF 88 and SF 78) are used when collecting patient data. Elements on these forms are in the same sequence that they are entered in the computer. The system has been designed to be user friendly and requires no special skills to fully				
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SECTION 1. INTRODUCTION TO COSTAR-THE MEDICAL INFORMATION COMPONENT OF NOHIMS

The objective of the Navy Occupational Health Information Management System (NOHIMS) is to provide an information system that will coordinate the components of the Navy's occupational health program in order to meet the requirements of the Occupational Safety and Health Act of 1970. NOHIMS consists of two subsystems: (1) an industrial information component and (2) a medical information component. The industrial information component performs all of the functions required to identify individuals at risk and to insure that they are examined periodically. Therefore, the industrial subsystem contains personnel and environmental data. The industrial information component of NOHIMS has been designed and developed by the Naval Health Research Center. The medical information component of NOHIMS consists of COSTAR---the Computer Stored Ambulatory Record system. COSTAR is a comprehensive and flexible medical information and communication system that can be adapted to the user's setting and information needs. COSTAR stands for Computer-Stored Ambulatory Record and is a trademark owned by the Massachusetts General Hospital. The version of COSTAR that you will be using is an adaptation of COSTAR for Navy occupational medicine.

NOHIMS captures, stores, displays, and prints relevant, complete, and standardized information so that it is immediately and perpetually accessible. Further, the system has the capability to generate required reports in a timely manner, tabulate population statistics, and answer research queries far more accurately and efficiently than these tasks can be accomplished manually.

In designing and developing NOHIMS, every effort has been made to make the system easy to use. The following characteristics of NOHIMS operation facilitate the work flow in an occupational health unit while permitting complex information processing to take place.

- . Special forms have been designed to collect medical record data used by NOHIMS. These consist of a Patient Registration Form, a Physical Exam Data Sheet (PEDS) and Physical Examination Findings (PEX) Encounter Form, an Asbestos Surveillance Encounter Form, an Occupational History Questionnaire, and a Medical History Questionnaire. The data recorded on these forms appear in the same sequence that they are entered into NOHIMS, making data entry straightforward and easy.
- . Information is entered into NOHIMS by using a video terminal which communicates with a computer. This terminal has a typewriter-like keyboard for entering information into the computer, and it has a television-like screen for displaying information going to or coming from the computer. No special skills are required to fully use the terminal.

- Communication with the computer is accomplished through telephone lines between the computer and the terminal at the occupational health unit. If this telephone connection is continuous, the system is said to be on-line, allowing immediate access to the information stored in NOHIMS whenever required.
- NOHIMS communicates with the user at the terminal in an interactive question and answer dialogue. The system recognizes what option the user selects and then prompts the user for appropriate information. Additions or changes to information already entered into the system can also be made interactively.
- NOHIMS incorporates a number of "user friendly" features. Certain types of information entered into the system are immediately checked for validity and reported to the user for acceptance or re-entry. When the user is in doubt about how to respond to a prompt, help is available by simply entering a question mark. The system then responds by specifying the type of data to be entered, by displaying a list of alternatives, or by providing detailed instructions on how to proceed. Use of the question mark (called the ? command) makes NOHIMS self-instructional.

There are six primary system options available for use in the medical information component of NOHIMS as follows:

REGISTRATION
ENTER MEDICAL DATA
DISPLAY MEDICAL DATA
PRINT MEDICAL DATA
COSTAR REPORT GENERATOR
MAILBOX

- Registration. This option provides for the capture, entry, update, and display of all identifying and demographic data for the patient. A patient must be registered in NOHIMS before any encounter data or history data can be entered into the patient's medical record.
- Enter Medical Data. This option allows entry and edit of encounter or history data in the patient's medical record.
- Display Medical Data. This option allows data in a patient's medical record to be displayed or printed in a variety of formats and sequences.

- . Print Medical Data. This option is used to produce all standard hard copy medical reports for patients individually or for a group of patients as a whole.
- . COSTAR Report Generator. This option provides the capability of producing listings and tabulations of selected information stored in NOHIMS. Additionally, percentages, percent deviations, totals, and subtotals may be computed for any specified distribution. This option serves as a tool to satisfy information needs not met by the standardized COSTAR reports available in NOHIMS.
- . Mailbox. This option allows you to send mail to other system users, to display or print the mail you have received, or to delete any or all messages in your mailbox. The NOHIMS system manager may also send messages of general interest and importance to all system users.

A more detailed description of each of these six NOHIMS options is provided in this users' manual along with instructional examples of how to use the system. But first you need to become familiar with certain conventions that NOHIMS follows in order for you to use the system correctly and efficiently. These conventions are explained in the next section.

SECTION 2. NOHIMS CONVENTIONS

1. Your System Manager will provide the exact sign-on procedures to allow you access to NOHIMS COSTAR.
2. When NOHIMS receives the correct Username, the following prompt will be displayed.

ID CODE >

The NOHIMS system manager will have assigned you a unique code to use as part of NOHIMS's security features. Remember to press the RETURN key after you enter your ID Code.

3. Each response that you type must end with the RETURN key. The RETURN signal lets NOHIMS know that you have entered your response and are waiting for the next prompt from NOHIMS. No character is displayed on your terminal when you press the RETURN key.
4. Each time NOHIMS requests a response from you, it displays a right caret (>) to let you know that it is waiting for a response. This symbol is called a prompt. If you are working with the ENTER MEDICAL DATA system option, a triple caret (>>>) also is used as a prompt for entry of medical data.
5. When typing a response to a NOHIMS system request or a system option prompt, you may type in the entire word or just enough letters for the response to be uniquely identified from all other responses appropriate to the prompt.
6. NOHIMS sometimes has a short attention span. If you do not respond to a prompt within three minutes, NOHIMS will time out, returning you to the first request in the series with which you are working. If you have just logged on, NOHIMS logs you off.
7. When NOHIMS does not require a response to a particular prompt, you may go on to the next request by pressing the RETURN key. This action returns nothing new to NOHIMS.
8. Some NOHIMS requests are followed by information contained within carets <information>. This information is the default response to the request. If you press the RETURN key, NOHIMS will use this information as your response. If the information within carets is not the appropriate response, type in the correct information on the same line and press the RETURN key. NOHIMS will substitute the information you have entered instead of the default response.
9. Whenever you have a question about how to respond to a NOHIMS prompt, use the ? command. Type a question mark (?) followed by the RETURN key. NOHIMS then will display the appropriate responses or form of response followed by the original request, or NOHIMS will give you further instructions.

10. When NOHIMS requests have a specific but a relatively long list of allowable responses, the ? command yields only the kinds of responses allowed. To obtain the list of allowable responses, use the ^L command. Type ^L followed by the RETURN key.
11. To erase a character---or a continuous string of characters---before the RETURN key is pressed, use the DELETE or RUBOUT key. Each time the DELETE key is pressed on a printing terminal, NOHIMS prints a back slash (\) to help you keep track of the number of characters that have been deleted. On a video terminal, NOHIMS back spaces instead to delete the characters.
12. To erase an entire line that has been typed before the RETURN key has been pressed, use the CTRL U command. Hold down the CTRL key while typing a U. (CAUTION: Do not confuse the CTRL U command with ^U, which are the characters displayed after typing the CTRL U command. Simply typing the characters ^U will not work.)
13. To make a correction after the RETURN key has been pressed, use the ^ command. Type ^. This command results in a display of the previous request, with your response displayed within carets < >. You then may edit your response by typing in the correct response, delete the response by typing a minus sign (-), or accept the response by pressing RETURN.
14. To return to the first request within a series, use the ^Q command. Type ^Q. The ^Q command yields the first request of the series in which you are working. The ^Q command also is used to EXIT or log off from NOHIMS; type ^Q after each prompt until NOHIMS ceases to display prompts and instead displays the EXIT cue.
15. The standard NOHIMS format for typing in dates is MM/DD/YY, where MM stands for the numeric representation of the month, DD stands for the day of the month, and YY stands for the last two digits of the year. Dates also may be entered in an abbreviated form as follows:

MM/DD	Assumes This Year
DD	Assumes This Month and Year
T	Today
T+N	Today + Number Entered (T+1 = Tomorrow, etc.)
T-N	Today - Number Entered (T-1 = Yesterday, etc.)

16. An occupational health care provider is identified by name in the following form: LAST,FIRST. NOHIMS requires only enough letters to identify uniquely one provider from all others. Usually two or three letters of the last name are enough, e.g., SM for SMITH.

17. A PATIENT may be identified by the PATIENT's social security number (SSN). This patient identification must be entered in the following format:
First three digits of the SSN followed by a hyphen, then the next two digits of the SSN followed by another hyphen, and then the last four digits of the SSN.
18. When a PATIENT's social security number is not known or is not available, the PATIENT may be identified by name, sex, and date of birth (DOB) or age in the following form:

LAST,FIRST;S;MM/DD/YY

For example, LEWIS,ROBERT;M;12/3/63

or

LAST,FIRST;S;AGE

For example, LEWIS,ROBERT;M;20

The LAST name may be abbreviated to its first two letters; the FIRST name may be abbreviated to its first letter or replaced by an asterisk (*) if unknown or uncertain; and SEX or DOB/AGE may be omitted if unknown. However, you should enter SEX if you know it because it narrows the search and speeds it up considerably. The following are some examples of the permissible forms used to identify and select a PATIENT.

LAST;
LA,F;S;MM/DD/YY
LA,UNK;S;AGE
LA,F;UNK;AGE
LA,F;S;
LA,F;
LA,UNK;

For example, LEWIS;
For example, LE,R;M;12/3/63
For example, LE,*;M;20
For example, LE,R;;20
For example, LE,R;M;
For example, LE,R;
For example, LE,*;

19. Throughout this users' manual, underlining _____ will be used to show what or where you are to type.

SECTION 3. REGISTRATION

When a new patient reports to the occupational health unit to see an occupational health care provider, there are a number of pieces of information that need to be collected. The occupational health technician or nurse will hand each new patient a Patient Registration Form (see Exhibit 1 on the next page) and ask the patient to complete the form by responding to all items. After the Patient Registration Form is completed, someone must enter the registration information into the system. REMEMBER, you cannot enter any encounter or history data into NOHIMS until a patient is registered.

If you are responsible for entering registration information into NOHIMS, you would log onto the system by entering your ID Code in response to the ID CODE prompt. When you press the RETURN key, NOHIMS displays the SYSTEM OPTION prompt. If you type in a question mark (?) in response to this prompt, NOHIMS will display the seven primary system options available in the medical information component for your selection as shown below.

SYSTEM OPTION > ? RETURN

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

REGISTRATION
ENTER MEDICAL DATA
DISPLAY MEDICAL DATA
PRINT MEDICAL DATA
COSTAR REPORT GENERATOR
MAILBOX

SYSTEM OPTION > REGISTRATION RETURN

You need only type in those characters of the system option you want to select that uniquely identify it. In this case, the letter R (shown by the underlining) is enough to select REGISTRATION. When you press the RETURN key, NOHIMS will supply the rest of the letters. Next, NOHIMS will ask what it is that you want to do with Registration by displaying the REGISTRATION OPTION prompt. Again by typing a ? or an ^L, NOHIMS will list the possible Registration Options for your choice as shown below.

REGISTRATION OPTION > RETURN

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

PATIENT REGISTRATION/EDIT
DISPLAY REGISTRATION

REGISTRATION OPTION >

Exhibit 1

OCCUPATIONAL HEALTH CARE
PATIENT REGISTRATION FORM

THIS PAGE TO BE COMPLETED BY THE PATIENT. RESPOND TO ALL ITEMS. PLEASE PRINT.

PATIENT NAME

Workman John Q
LAST NAME FIRST NAME M.I.

SEX

☒ (M) Male ☐ (F) Female

DATE OF BIRTH

9 - 3 - 49
MONTH DAY YEAR

PERSON TO NOTIFY IN EMERGENCY (Optional)

Name: Workman Sara
LAST NAME FIRST NAME M.I.

Street Address: 368 Mar Vista

City: San Diego State: CA

Zip Code: 92158 Telephone Number: 619/225-8935

TODAY'S DATE (Date of Registration)

6 - 18 - 84
MONTH DAY YEAR

SOCIAL SECURITY NUMBER (SSN)

361 - 30 - 4161

DUTY STATION OR ACTIVITY

- | | |
|---|--|
| <input type="checkbox"/> (0) Naval Supply Center | <input type="checkbox"/> (4) Public Works Center |
| <input checked="" type="checkbox"/> (1) Naval Air Rework Facility | <input type="checkbox"/> (5) Special Services |
| <input type="checkbox"/> (2) Naval Air Station N. I. | <input type="checkbox"/> (6) Navy Exchange |
| <input type="checkbox"/> (3) Naval Amphibious Base | <input type="checkbox"/> (7) Other (Specify) _____ |

PRIMARY CLINIC

- | | |
|--|--------------------------------------|
| <input checked="" type="checkbox"/> (1) North Island | <input type="checkbox"/> (4) Balboa |
| <input type="checkbox"/> (2) 32nd Street | <input type="checkbox"/> (5) Miramar |
| <input type="checkbox"/> (3) NOSC | <input type="checkbox"/> (6) Other |

NHRC [09-30-85]

First we will register a patient in NOHIMS, and then we will display the registration data we have just entered.

PATIENT REGISTRATION - EXAMPLE 1

When the Patient Registration/Edit option is selected in response to the REGISTRATION OPTION prompt, NOHIMS asks you to identify the patient as follows.

REGISTRATION OPTION > PATIENT REGISTRATION/EDIT RETURN

Identify Patient >

In response to the Identify Patient prompt, type in the patient name in the following format---the first two letters of the last name followed by a comma, no space, then the first letter of the first name. After you identify the patient, NOHIMS will search its files to find registered patients with the same characters in the name. If NOHIMS does not find any patients matching the characters you have entered, NOHIMS will ask you to verify that this is a new patient as shown below.

Identify Patient > LA,F RETURN
New patient named <<LA,F>> <Yes> N RETURN

Identify Patient > LAST,FIRST RETURN
New patient named <<LAST,FIRST>> <Yes> ? RETURN

We entered N for No at the first New patient named prompt because the patient's name is actually LAST,FIRST, not LA,F. When NOHIMS returned us to the Identify Patient prompt, we entered the entire name. We entered only a few letters of the name at the first prompt so that we could be sure that we did not register this patient twice with slightly different spellings of the same name.

If there were more than one patient whose name began with the same characters (LA,F), NOHIMS would display a list of these patients. If NOHIMS displays a list, you should compare the name and unit number (the Social Security Number) of each patient in the list to the patient you are trying to register to see if any match or come close to matching. If you are unsure if there is a match or not, call your NOHIMS System Manager for help in deciding. If there is a match, that patient is already registered in NOHIMS. Select the number of the patient. NOHIMS will display the registration data for the patient and allow you to edit/ update the data items (the edit process will be described in detail later). Then you should go on to the next Patient Registration Form. However, if there is not a match, then press RETURN at the Item # or Quit prompt. NOHIMS will respond with the New patient named prompt. Again, type N for No so that NOHIMS will return you to the Identify Patient prompt. You then may enter the entire name of the patient knowing that this patient is not already registered in the NOHIMS database. This sequence is shown in the following example for a patient named John Q. Workman.

Identify Patient > WO,J RETURN

1 WOLINSKY, JACOB	M 3/4/62	367-58-9241	P
2 WORTHINGTON, JAMES	M 9/3/60	565-61-7830	P

Item # or Quit > RETURN

New patient named <WO,J> <Yes> ? N RETURN

Identify Patient > WORKMAN, JOHN Q RETURN

New patient named <WORKMAN, JOHN Q> <Yes> ? RETURN

After you press RETURN to accept Yes, NOHIMS then sets up the PATIENT DISPLAY format, filling in the patient's name. NOHIMS will prompt for the patient's sex next, and then the date of birth and other registration data items as shown below.

..... PATIENT DISPLAY.....

WORKMAN, JOHN Q ()
NOTIFY IN EMERGENCY:

DATE OF REGISTRATION:

SSN:

DUTY STATION OR ACTIVITY . . .

PRIMARY CLINIC

ETHNIC BACKGROUND.

SEX> M RETURN

DATE OF BIRTH> 9/3/49 RETURN

For more rapid entry of the patient's name, sex, and date of birth, you may enter PATIENT NAME, SEX, and DATE OF BIRTH at the same time on one line. Instead of pressing RETURN after typing the patient's full name at the second Identify Patient prompt, type a semicolon (;) followed by the patient's sex (M or F), and then another semicolon followed by the DATE OF BIRTH. The entry would look like the following.

Identify Patient > WORKMAN, JOHN Q;M;9/3/49 RETURN
New patient named <<WORKMAN, JOHN Q>> <Yes> ? RETURN

After you press RETURN to accept Yes, NOHIMS will set up the PATIENT DISPLAY format, filling in the patient's identifying data known at this point which consists of the patient's name, sex, and date of birth. NOHIMS will then prompt for the person to NOTIFY IN EMERGENCY, the next registration data item.

..... PATIENT DISPLAY.....

WORKMAN,JOHN Q (M) 9/3/49
NOTIFY IN EMERGENCY:

DATE OF REGISTRATION:

SSN:

DUTY STATION OR ACTIVITY . . .

PRIMARY CLINIC

ETHNIC BACKGROUND.

NOTIFY IN EMERGENCY >

Try entering PATIENT NAME, SEX, and DATE OF BIRTH both the long way and the rapid way. Use the way that is most comfortable for you. The same information is filed in NOHIMS regardless of which way you use to enter the data.

NOTIFY IN EMERGENCY is an optional data field on the Patient Registration Form, that is, the patient is not required to provide this information. However, if a person's name has been written in this field on the Patient Registration Form, type it in response to the NOTIFY IN EMERGENCY prompt. Use the same format that you used for entering the patient's name---last name followed by a comma, no space, then first name. If there is a middle initial, enter a space after the first name and then type the middle initial. When you press the RETURN key, NOHIMS prompts for Address Line. Type the Street Address written on the Patient Registration Form and press RETURN. NOHIMS next prompts for Zip Code. NOHIMS already has a ZIP CODE Directory stored in its files to save you time. When you enter the Zip Code, NOHIMS supplies the City and State so that you do not have to type it in. If you enter a Zip Code which is not in the Directory, NOHIMS will ask you to type in the City and State. The sequence of prompts for entering information about the person to Notify in Emergency looks like the following.

NOTIFY IN EMERGENCY> WORKMAN, SARA

Address Line > 368 MAR VISTA

Zip Code > 92158

City, State <SAN DIEGO, CA

NOHIMS supplied it.

RETURN

RETURN

RETURN

RETURN

After you have responded to all of these four prompts, NOHIMS adds the new information to the PATIENT DISPLAY at the top of the screen on your terminal. Next NOHIMS prompts for PHONE NUMBER IN EMERGENCY. Type the Telephone Number exactly as written on the Patient Registration Form, for example, 619/225-8935. If there is no Area Code, type just the local number.

PHONE NUMBER IN EMERGENCY> 619/225-8935

RETURN

If the patient has not written anything in the PERSON TO NOTIFY IN EMERGENCY data field, you may skip past all of these prompts by pressing the RETURN key at each prompt.

Next NOHIMS prompts for DATE OF REGISTRATION. Enter the date written on the Patient Registration Form in MM/DD/YY format, for example, 6/17/84. You may also use the T convention as explained on page 2-2.

DATE OF REGISTRATION> 6/17/84

RETURN

NOHIMS prompts next for Social Security Number. The Social Security Number (SSN) must be typed in a particular format. Otherwise, NOHIMS will not accept your entry. Type the first three digits of the SSN followed by a hyphen, then the next two digits of the SSN followed by another hyphen, and then the last four digits of the SSN. When you press RETURN, NOHIMS will echo back the numbers you have just entered as the Unit Number in NOHIMS. Each patient's Unit Number is unique and provides another way of identifying patients in the NOHIMS database. A correct entry of SSN should look like the following.

SOCIAL SECURITY NUMBER> 367-30-4761

Unit number: 367-30-4761

RETURN

NOHIMS echoes this back.

If the Social Security Number you have entered has already been used in the NOHIMS database, NOHIMS will display the corresponding patient name, sex, and date of birth and then respond with the following message.

Unit number is already in use

SOCIAL SECURITY NUMBER> ^Q

Ignore or Continue> IGNORE

...ignored

RETURN

RETURN

Identify Patient > SSN

RETURN

At the Social Security Number prompt, you should enter ^Q to discontinue registering this patient. NOHIMS will ask you if it should ignore what registration data you have already entered for this patient or continue the registration process. You should enter I for Ignore to get back to the Identify Patient prompt. When this prompt appears, enter the patient's SSN. NOHIMS then will display a line showing the patient's name, sex, date of birth, and SSN so that you can determine exactly how this patient was registered and any errors there may be in the data shown on this line. If there are errors, they can be corrected using the PATIENT REGISTRATION/EDIT option explained later in this section.

However, let's assume for this example of PATIENT REGISTRATION that we are registering a new patient and that NOHIMS has echoed back the SSN we just have entered. NOHIMS then adds this information to the growing PATIENT DISPLAY at the top of your terminal screen and prompts for DUTY STATION OR ACTIVITY. Type in the number shown in parentheses next to the box checked by the patient on the Patient Registration Form. If the patient has checked the box for Naval Air Rework Facility, you would type in 1. NOHIMS then provides the complete entry as follows.

```
DUTY STATION OR ACTIVITY>  
> 1 NAVAL AIR REWORK FACILITY          RETURN
```

Then NOHIMS prompts for PRIMARY CLINIC. You always type in the number shown in parentheses next to the box checked by the patient.

```
PRIMARY CLINIC> 1 NORTH ISLAND          RETURN
```

ETHNIC BACKGROUND works the same way, as shown in the following example. Once again you type in the number shown in parentheses next to the box checked by the patient.

```
ETHNIC BACKGROUND>  
> 1 CAUCASIAN          RETURN
```

All of this new information is also added to the PATIENT DISPLAY. You now have completed the data entry sequence for Patient Registration. When you press RETURN after typing the checked response for ETHNIC BACKGROUND, NOHIMS returns with the following prompt: Patient item >. NOHIMS is giving you a chance to edit any of your entries before you file the Patient Registration information in the NOHIMS database. You should compare what is written on the Patient Registration Form with the PATIENT DISPLAY at the top of your terminal screen to make certain that all your entries are correct. If you spot an error, you can enter the Registration Item Name in response to the Patient item prompt and make a correction. NOHIMS displays the old information within carets (< >) and allows you to type in the corrected entry. Let's suppose we made a mistake in entering the DATE OF REGISTRATION and notice it at this time. We could make the correction by responding as follows to differentiate the Patient Item we want from DATE OF BIRTH.

Patient item > DATE OF REGISTRATION <6/17/84> 6/18/84 RETURN

Patient item > RETURN

We have changed the Date of Registration from 6/17/84 to 6/18/84. NOHIMS then redisplay the Patient item prompt, allowing us to make other changes as well. If there are no more corrections to the Patient Registration information we have just entered, then we press RETURN in response to the last Patient item prompt. NOHIMS then returns with the following prompt: File, Edit or Ignore>. We have a final chance to edit our entries before filing them, or we can ask NOHIMS to ignore everything we have entered if for some reason we decide not to register the patient at this point. You would type an E to Edit or an I to Ignore. Let's assume we are satisfied that all of our entries are correct, so we elect to File.

File, Edit or Ignore> FILE RETURN
...Please wait while filing....

NOHIMS lets us know that the system is filing all of the Patient Registration information for this patient and asks us to wait. When it is through filing, NOHIMS returns with the Identify Patient prompt. Now you are ready to register another new patient. If you are done registering patients, then press RETURN to select another Registration Option as shown below.

Identify Patient > RETURN

REGISTRATION OPTION >

From this point on, you will not be reminded to press RETURN each time that you want to enter the data you have just typed. However, underlining will continue to be used to show the character(s) necessary for entering specific data items or responses.

DISPLAY REGISTRATION - EXAMPLE 1

Just to be certain that the Patient Registration information for John Q. Workman has been properly filed in NOHIMS, let's display it. The display should look exactly like the PATIENT DISPLAY at the top of the terminal screen when we finished entering all of the Patient Registration information. We review a patient's registration information as follows.

SYSTEM OPTION > REGISTRATION

REGISTRATION OPTION > DISPLAY REGISTRATION

NAME OR UNIT # > WO,J;M;9/3/49

WORKMAN,JOHN Q

M 9/3/49

367-30-4761

P

Is this the person ? <Y>

We have used the rapid method of identifying a patient. Unlike PATIENT REGISTRATION/EDIT, DISPLAY REGISTRATION uses the patient name, sex, and date of birth to search for the particular patient we want to display. If we did not use the rapid method of identifying a patient, by entering all of the data at the NAME OR UNIT # prompt, then NOHIMS would prompt for sex and date of birth after we entered the name. NOHIMS finds a patient that matches the characters we have entered in response to the NAME OR UNIT # prompt and then asks us, Is this the person? The default response is Yes. If we are satisfied that this is the patient whose registration data we want to display, then we simply press RETURN. NOHIMS will generate the PATIENT DISPLAY as shown below.

..... PATIENT DISPLAY.....

WORKMAN,JOHN Q

(M) 9/3/49

NOTIFY IN EMERGENCY: WORKMAN,SARA
368 MAR VISTA
SAN DIEGO,CA 92158
619/225-8935

DATE OF REGISTRATION: 6/18/84

SSN: 367-30-4761

DUTY STATION OR ACTIVITY . . . 1 NAVAL AIR REWORK FACILITY

PRIMARY CLINIC 1 NORTH ISLAND

ETHNIC BACKGROUND. 1 CAUCASIAN

REGISTRATION OPTION >

After generating the PATIENT DISPLAY, NOHIMS returns to the REGISTRATION OPTION prompt, allowing you to select another Registration Option, to move on to another primary system option, or to EXIT from the system. Remember that the DISPLAY REGISTRATION option only allows you to review the Patient Registration information. You cannot change it through this option. If you need to edit any item of Patient Registration information, you must use the PATIENT REGISTRATION/ EDIT option as explained next.

EDIT OF PATIENT REGISTRATION

Let's suppose that John Q. Workman's Duty Station or Activity is actually the Public Works Center and his Phone Number in Emergency is really 619/224-8935. Since he has already been registered in NOHIMS, we must use the PATIENT REGISTRATION/EDIT option to make these two corrections. At the REGISTRATION OPTION prompt, select this option as follows.

REGISTRATION OPTION > PATIENT REGISTRATION/EDIT

Identify Patient > WO,J

1 WOLINSKY, JACOB	M 3/4/62	367-58-9241	P
2 WORKMAN, JOHN Q	M 9/13/49	367-30-4761	P
3 WORTHINGTON, JAMES	M 9/30/60	565-61-7830	P

Item # or Quit > 2

NOHIMS finds several patients in response to our entry of WO,J at the Identify Patient prompt. Notice that we did not enter the sex and date of birth because we are using the PATIENT REGISTRATION/EDIT option. This means that NOHIMS will just search the database for name matches. When we select 2 at the Item # or Quit prompt, NOHIMS responds by displaying the patient registration information for John Q. Workman followed by the Patient item prompt. Type an ^L if you want to see a list of all available patient items, or refer to the chart of possible patient items in NOHIMS registration. At the Patient item prompt, we can make our two corrections.

..... PATIENT DISPLAY

WORKMAN, JOHN Q (M) 9/13/49
NOTIFY IN EMERGENCY: WORKMAN, SARA
368 MAR VISTA
SAN DIEGO, CA 92158
619/225-8935

DATE OF REGISTRATION: 6/18/84

SSN: 367-30-4761

DUTY STATION OR ACTIVITY . . . 1 NAVAL AIR REWORK FACILITY

PRIMARY CLINIC 1 NORTH ISLAND

ETHNIC BACKGROUND. 1 CAUCASIAN

Patient item > DUTY STATION OR ACTIVITY <1 NAVAL AIR REWORK FACILITY>
> 4 PUBLIC WORKS CENTER

Patient item > P&

At the first Patient item prompt, we corrected John Q. Workman's Duty Station or Activity. But what happened at the second Patient item prompt? We entered P for the first letter of PHONE and pressed the RETURN key. NOHIMS displayed an ampersand (&) to advise us that we did not enter enough letters to uniquely identify PHONE NUMBER IN EMERGENCY. So what do we do next? We have two choices. If we press the RETURN key, NOHIMS simply displays another ampersand. However, we can enter an H and hope that the P&H will be enough characters to uniquely identify the patient item we want. Or we can refer to the chart of possible patient items in NOHIMS registration to determine how many characters we have to enter. If we can't find the chart, then we may use the ^ command to get back to the Patient item prompt so that we can get help from NOHIMS. Let's try using the ^ command here and see what happens.

```
Patient item > P&^ ...Not found
```

```
Patient item >
```

If we type ^L in response to the Patient item prompt, we would see that in the list of responses there are three items that begin with the letter P---PATIENT NAME, PHONE NUMBER IN EMERGENCY, and PRIMARY CLINIC. Therefore, we have to enter the letters PH to let NOHIMS know which of these three items is the one that we want to change.

```
Patient item > PHONE NUMBER IN EMERGENCY <619/225-8935>  
> 619/224-8935
```

```
Patient item >
```

Now we have correctly changed John Q. Workman's Phone Number in Emergency. Since we are done making these two corrections, we simply press RETURN at the last Patient item prompt. NOHIMS then returns with the following prompt.

```
File, Edit or Ignore> FILE  
...Please wait while filing....
```

```
Identify Patient >
```

After we enter F to FILE, NOHIMS informs us that it is filing the corrected patient registration data and asks us to wait. When the filing is completed, NOHIMS returns with the Identify Patient prompt. Now you may edit another patient's registration information, register a new patient, select a different Registration Option, move on to another primary system option, or EXIT from the system.

PATIENT REGISTRATION - EXAMPLE 2

In this example, we will register another patient---a female named Marjorie Reyes. Select the PATIENT REGISTRATION/EDIT option in response to the REGISTRATION OPTION prompt, and then identify the patient as follows.

REGISTRATION OPTION > PATIENT REGISTRATION/EDIT

Identify Patient > RE,M

New patient named <<RE,M>> <Yes> ? N

Identify Patient > REYES,MARJORIE;F;10/20/59

New patient named <<REYES,MARJORIE>> <Yes> ?

When the RETURN key is pressed to accept Yes, NOHIMS then sets up the PATIENT DISPLAY and continues to prompt for the remaining patient items in the registration prompt sequence.

..... PATIENT DISPLAY

REYES,MARJORIE

(F) 10/20/59

The next prompt is NOTIFY IN EMERGENCY. Let's assume that Marjorie Reyes did not write anything in this optional data field. When the PERSON TO NOTIFY IN EMERGENCY data field is left blank on the Patient Registration Form, you may skip past this prompt and the PHONE NUMBER IN EMERGENCY prompt which follows by pressing the RETURN key at each of these prompts. This action returns no new information to NOHIMS. NOHIMS then moves on to the next prompt in the Registration prompt sequence. The remaining prompts and your responses to them might look like the following.

DATE OF REGISTRATION> 6/22/84

SOCIAL SECURITY NUMBER> 612-83-5611

Unit number: 612-83-5611

DUTY STATION OR ACTIVITY>

> 3 NAVAL AMPHIBIOUS BASE

PRIMARY CLINIC> 3 NOSC

ETHNIC BACKGROUND>

> 2 BLACK

As you enter your response at each prompt and press the RETURN key, the new information is added to the PATIENT DISPLAY. After you enter your response to ETHNIC BACKGROUND, which is the last prompt in the Registration prompt sequence, NOHIMS returns with the Patient item prompt. If you notice any errors in your data entry for this patient's registration data as you compare what is written on the Patient Registration Form with the PATIENT DISPLAY at the top of your terminal screen, you can edit any of your entries before filing by entering enough characters of the name of the Registration Item to uniquely identify it. Use the ^L command if you cannot remember all of the names of the Registration Items, or refer to the chart of possible patient items in NOHIMS registration. If you are satisfied that all of your data entries are correct, you simply press RETURN at the Patient item prompt and then type F at the File, Edit or Ignore prompt in order to FILE the registration data for Marjorie Reyes as shown below.

```
Patient item >
File, Edit or Ignore> FILE
...Please wait while filing....
```

```
Identify Patient >
```

If, while entering Registration data, you notice that you made an entry error for a previous item, you can return to that item by typing (^) at each prompt until NOHIMS returns you to the prompt you want to change. The (^) tells NOHIMS to display the previous prompt, along with the information you entered within carets (< >). You can change the information by typing new information, keep the old information by pressing RETURN, or type another (^) to go to the next previous prompt. This is a useful function if you do not want to wait until you reach the Patient item prompt to correct or review an entry. The following is an example of returning to the DUTY STATION OR ACTIVITY prompt from ETHNIC BACKGROUND.

```
ETHNIC BACKGROUND>
> ^
PRIMARY CLINIC <3 NOSC>
> ^
DUTY STATION OR ACTIVITY <3 NAVAL AMPHIBIOUS BASE>>
> 4 PUBLIC WORKS CENTER
PRIMARY CLINIC <3 NOSC>
>
ETHNIC BACKGROUND>
>
```

DISPLAY REGISTRATION - EXAMPLE 2

Let's display the patient registration information for Moira Decker, another patient in the NOHIMS database. We might respond as follows to NOHIMS' prompts.

SYSTEM OPTION > REGISTRATION

REGISTRATION OPTION > DISPLAY REGISTRATION

NAME OR UNIT # > DW,M;F;
Person not found.

NOHIMS did not find any patient matching the characters we entered at the NAME OR UNIT # prompt. It's no wonder; we made an error in data entry. The second character should have been an E instead of a W. Let's try it again and get it right.

NAME OR UNIT # > DE,M;F;

1 DECKER,MOIRA	F 3/8/62	612-83-5611	P
2 DELGADO,MARIA	F 11/16/60	351-22-3437	P
3 DELGADO,MARITZA T	F 6/7/61	537-98-4375	P
4 DELGADO,MELANIE A	F 8/23/53	537-98-4376	P

Item # or Quit >

What happened here? NOHIMS found four female patients that matched the characters we entered in response to the NAME OR UNIT # prompt. If we had entered DEC,M;F; instead of DE,M;F; as is shown above, NOHIMS would have only found Item 1. The more characters you enter, the easier it is for NOHIMS to find the right patient. If the database is large or if the patient's last name is a common name, it will save time to enter a few more letters and help NOHIMS narrow the search through the database.

The patient we want is Moira Decker shown as Item 1 in the previous list. When we enter 1 in response to the Item # or Quit prompt, NOHIMS generates the PATIENT DISPLAY for Moira Decker as shown next.

Item # or Quit > 1

..... PATIENT DISPLAY

DECKER, MOIRA

(F) 3/8/62

DATE OF REGISTRATION: 6/22/84

SSN: 612-83-5611

DUTY STATION OR ACTIVITY . . . 3 NAVAL AMPHIBIOUS BASE

PRIMARY CLINIC 3 NOSC

ETHNIC BACKGROUND. 2 BLACK

REGISTRATION >

Notice that in this PATIENT DISPLAY the data field for NOTIFY IN EMERGENCY is absent. The reason this data field is absent is because both the NOTIFY IN EMERGENCY and PHONE NUMBER IN EMERGENCY prompts were skipped over without making a response when the patient registration information was entered. You should skip over these two prompts on registration data entry only if the patient has left the PERSON TO NOTIFY IN EMERGENCY data field blank on the Patient Registration Form.

After NOHIMS finishes generating the PATIENT DISPLAY, it returns to the REGISTRATION OPTION prompt. Now you may select another Registration Option, move on to another primary system option, or EXIT from the system.

SECTION 4. ENTER MEDICAL DATA

The Medical Data Module in NOHIMS can store, edit, and retrieve information associated with patients' visits. There are three primary system options in the Medical Data Module---ENTER MEDICAL DATA, DISPLAY MEDICAL DATA, and PRINT MEDICAL DATA. The first of these three options is described in detail in this section. The other two options are described in Sections 5 and 6.

When you select ENTER MEDICAL DATA at the System Option prompt, NOHIMS next will prompt for a specific ENTER MEDICAL DATA option. If you type a question mark (?) in response to this prompt, NOHIMS will list the three possible choices as shown below.

SYSTEM OPTION > ENTER MEDICAL DATA

ENTER MEDICAL DATA OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

ENCOUNTER
LAB RESULTS
MEDICAL EDIT

The first function---the ENCOUNTER option---is used to enter the information recorded on the Encounter Form into the NOHIMS patient files. The LAB RESULTS option is used to enter the results of lab tests that have been ordered for a patient. MEDICAL EDIT permits you to locate a stored encounter and to edit its contents.

ENCOUNTER ENTRY - PHYSICAL EXAM DATA SHEET (PEDS) AND PHYSICAL EXAMINATION FINDINGS (PEX) ENCOUNTER FORM

The basic document that is used to enter medical data into the NOHIMS files is the ENCOUNTER FORM. A number of Encounter Forms are used in NOHIMS, one of which is the Physical Exam Data Sheet (PEDS) and Physical Examination Findings (PEX) Encounter Form. An example of this 8-page form is shown in Exhibit 2. The PEDS/PEX Encounter Form is used to record patient data collected during physical examinations at the Occupational Health Unit.

The example of the PEDS/PEX Encounter Form shown in Exhibit 2 contains typical data that might be collected during a scheduled physical examination for a civilian employee at the Naval Air Rework Facility. Beginning on page 4-10, you will be instructed how to enter all of the data shown on the example PEDS/PEX form into the NOHIMS database.

Exhibit 2

OCCUPATIONAL HEALTH CARE
PHYSICAL EXAM DATA SHEET ENCOUNTER FORM

P E D S

THIS PAGE TO BE COMPLETED BY THE PATIENT. RESPOND TO ALL ITEMS. PLEASE PRINT

PATIENT NAME		James C	
LAST NAME <u>Greeley</u>		FIRST NAME <u>James</u> M.I. <u>C</u>	
SEX	DATE OF BIRTH	PROVIDER NO. 1 (OFFICE USE ONLY)	
<input checked="" type="checkbox"/> (M) Male <input type="checkbox"/> (F) Female	<u>1</u> - <u>14</u> - <u>50</u> MONTH DAY YEAR	<u>Reed</u> LAST NAME	
TODAY'S DATE	SOCIAL SECURITY NUMBER	PROVIDER NO. 2 (OFFICE USE ONLY)	
<u>9</u> - <u>26</u> - <u>84</u> MONTH DAY YEAR	<u>061</u> - <u>32</u> - <u>1684</u>	<u>Nightingale</u> LAST NAME	
SITE OF ENCOUNTER			
(A) North Island			

TYPE OF EXAMINATION Check only one.

- | | |
|---|---|
| <input type="checkbox"/> (A) Pre-placement | <input type="checkbox"/> (H) Termination |
| <input type="checkbox"/> (B) Return to Work | <input type="checkbox"/> (I) Completion of Previous Visit
(Specify Date) <u>MM</u> <u>DD</u> <u>YY</u> |
| <input type="checkbox"/> (C) Fitness for Duty | <input type="checkbox"/> (J) Injury |
| <input type="checkbox"/> (D) Competence for Duty | <input type="checkbox"/> (K) Illness |
| <input type="checkbox"/> (E) Disability Retirement | <input type="checkbox"/> (O) Other (Specify) _____ |
| <input checked="" type="checkbox"/> (F) Periodic Exam (Includes Annual Phys.) | |
| <input type="checkbox"/> (G) Protective Equipment Only | |

VISIT CLASSIFICATION Check only one.

- | | |
|--|--|
| <input checked="" type="checkbox"/> (1) Civilian Scheduled Physical Exam | <input type="checkbox"/> (2) Military Scheduled Physical Exam |
| <input type="checkbox"/> (3) Civilian <u>Un</u> scheduled Physical Exam | <input type="checkbox"/> (4) Military <u>Un</u> sched. Physical Exam |

WORK INFORMATION

JT Job Title <u>A/C Engine Mechanic</u>	BLDG Building Number <u>32415</u>
WS Work Supervisor <u>Smith</u> <u>Mark</u> LAST FIRST	SHN Shop Number <u>95222</u>
	SHT Shop Tel. <u>431</u> - <u>4821</u>

****PATIENT: PLEASE STOP HERE. REST OF FORM IS FOR OFFICE USE ONLY****

NHRC [11-30-84]

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAM DATA SHEET ENCOUNTER FORM**

P E D S

JOB CERTIFICATION Check one ONLY if exam is for official job certification. (JC-)

- | | |
|---|--|
| <input type="checkbox"/> (A) Fireman/Firefighter | <input checked="" type="checkbox"/> (G) Aircraft Handler |
| <input type="checkbox"/> (B) Security Guard | <input type="checkbox"/> (H) Food Handler |
| <input type="checkbox"/> (C) Diver | <input type="checkbox"/> (I) Otto Fuel Worker |
| <input type="checkbox"/> (D) Motor Vehicle Operator | <input type="checkbox"/> (J) Corrosion Control/Painter |
| <input type="checkbox"/> (E) Crane/Construction Operator/Rigger | <input type="checkbox"/> (O*) Other (Specify) _____ |
| <input type="checkbox"/> (F) Explosive Handler | _____ |

HAZARDOUS AGENT SURVEILLANCE Check ALL that apply.

- | | |
|---|--|
| <input type="checkbox"/> ABD Abrasive Dust | <input type="checkbox"/> MC Methylene Chloride |
| <input type="checkbox"/> ACT Acetone | <input type="checkbox"/> MCA MOCA |
| <input type="checkbox"/> ALM Aluminum | <input type="checkbox"/> MLY Molybdenum Soluble |
| <input checked="" type="checkbox"/> ASB Asbestos | <input type="checkbox"/> NCK Nickel (inorganic) |
| <input type="checkbox"/> BNZ Benzene | <input type="checkbox"/> TNT 2-Nitropropane |
| <input type="checkbox"/> BRY Beryllium | <input checked="" type="checkbox"/> NS Noise |
| <input type="checkbox"/> CDM Cadmium | <input type="checkbox"/> NR Non-ionizing Radiation |
| <input type="checkbox"/> CHL Chlorinated Hydrocarbons | <input type="checkbox"/> ORG Organotin |
| <input type="checkbox"/> CHR Chromium | <input type="checkbox"/> PST Pesticides |
| <input type="checkbox"/> CB Cobalt | <input type="checkbox"/> PHB Phenylbetanaphthylamine |
| <input type="checkbox"/> DXN Dioxane | <input type="checkbox"/> PB Polychlorinated Biphenyls (PCBs) |
| <input type="checkbox"/> ETD Ethylene Dichloride | <input type="checkbox"/> TRP Tar Products |
| <input type="checkbox"/> IHZ Eye Hazards | <input type="checkbox"/> THS Thermal Stress |
| <input type="checkbox"/> HDZ Hydrazine | <input type="checkbox"/> TL Toluene |
| <input type="checkbox"/> IR Ionizing Radiation | <input type="checkbox"/> THN Trichloroethane |
| <input type="checkbox"/> IOF Iron Oxide Fume | <input type="checkbox"/> THY Trichloroethylene |
| <input type="checkbox"/> ISC Isocyanates (Polyurethane) | <input type="checkbox"/> VT Vibrating Tool |
| <input type="checkbox"/> ISA Isopropyl Alcohol | <input type="checkbox"/> VCH Vinyl Chloride |
| <input type="checkbox"/> LD Lead (inorganic) | <input type="checkbox"/> XY Xylene |
| <input checked="" type="checkbox"/> MRC Mercury (inorganic) | <input type="checkbox"/> HSO Other (Specify) _____ |
| <input type="checkbox"/> MEK Methyl Ethyl Ketone (Butanone) | _____ |

NHRC [11-30-84]

OCCUPATIONAL HEALTH CARE
PHYSICAL EXAM DATA SHEET ENCOUNTER FORM

P E D S

PROTECTIVE EQUIPMENT *Check ALL that apply.*

- ☐ RSP Respirator Fit/Program Applicant
☐ HRG Hearing Protection Fit
☐ OPF Other Protective Equipment Issued
(Specify) _____

LABORATORY TESTS *Check ALL that apply.*

- | | |
|--|---|
| <input checked="" type="checkbox"/> SMCB SMAC (Liver, Kidney, Blood Chemistry) | <input type="checkbox"/> HB Hemoglobin (CBC not done) |
| <input checked="" type="checkbox"/> UA Urinalysis | <input type="checkbox"/> HCT Hematocrit (CBC not done) |
| <input checked="" type="checkbox"/> CBC Complete Blood Count | <input type="checkbox"/> CMQ Carbon Monoxide, Quantitative |
| <input checked="" type="checkbox"/> DFF Differential Count | <input type="checkbox"/> Culture and Sensitivity (Specify Source) _____ |
| <input type="checkbox"/> HMC Heavy Metal Urine Copper | <input type="checkbox"/> HMD Heavy Metal Urine Cadmium |
| <input type="checkbox"/> HMB Heavy Metal Urine Beryllium | <input type="checkbox"/> HMA Heavy Metal Urine Arsenic |
| <input type="checkbox"/> HMM Heavy Metal Urine Mercury (inorg.) | <input type="checkbox"/> HML Heavy Metal Urine Lead (organic) |
| <input type="checkbox"/> HMSC Heavy Metal Serum Copper | <input type="checkbox"/> HMSZ Heavy Metal Serum Zinc |
| <input type="checkbox"/> BLD Blood Lead (inorganic) | <input type="checkbox"/> Other Heavy Metal (Specify) _____ |
| <input type="checkbox"/> Other Chemistry (Specify) _____ | <input type="checkbox"/> Other Chemistry (Specify) _____ |
| <input type="checkbox"/> Other Lab Test (Specify) _____ | <input type="checkbox"/> Other Lab Test (Specify) _____ |

RADIOLOGY *Check ALL that apply.*

- | | |
|--|---|
| <input type="checkbox"/> CPL Chest Xray PA & Lateral | <input checked="" type="checkbox"/> CSB Chest Xray Asbestos |
| <input type="checkbox"/> CBQ Chest Xray Oblique | <input type="checkbox"/> Other Xray (Specify) _____ |

PULMONARY FUNCTION TESTS *Check only one.*

- | | |
|--|--|
| <input checked="" type="checkbox"/> PFTA Pulmonary Function Testing for Asbestos | <input type="checkbox"/> PFTO Pulmonary Function Testing for Other Than Asbestos |
|--|--|

ELECTROCARDIOGRAMS

- ☐ EKG Electrocardiogram

AUDIOMETRY (Reason for Exam) *Check only one.*

- ☒ ENX Excessive Noise Exposure (Hearing Conservation Program)
☐ AOT Other Administrative Reason (Pre-placement, Return-to-Work, Disability, Retirement, Termination, Transfer, etc.)
☐ ECM Employee Complaint Only

EYE EXAMINATION --- OPTOMETRY DEPARTMENT

- ☐ To Be Done

NHRC [11-30-84]

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAMINATION FINDINGS**

P E X

SOCIAL SECURITY NUMBER

0 6 1 - 3 2 - 1 6 8 4

PROVIDER (PHYSICIAN ONLY)

Reed

LAST NAME

PHYSICIAN EXAMINATION Check only one.

☒ FPE Full Physician Exam
(Form 78 or equivalent)

☐ LPE Limited Physician Exam (such as
Respirator, Asbestos, Competence
for Duty, and other partial exams)

☐ OEPE Omitted Entire Physician Exam

☐ RPE Refused Entire Physician Exam

HT Height 69 inches

WT Weight 215 lbs.

VITAL SIGNS

TMP (Temperature) 98.4

PLS (Pulse) 18

RR (Respiratory Rate) 18

BP (Blood Pressure) 150/92

GENERAL APPEARANCE Check:
(GAX-)

If entire exam.....(N)ORMAL ☒

If any ABNORMALITIES, describe:
(A/GAB)

Obesity

SKIN Check:
(SKX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/SKB-)

- ☐ (F)ace or Neck ☐ (A)bdomen
☐ (U)pper Extrem. ☐ (G)roin or Buttocks
☐ (B)ack or Shldr. ☐ (L)ower Extrem.
☐ (C)hest or Axil. ☐ (O*)ther, specify:

Concise Comments(+):

EYES Check:
(EYX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/EYB-)

- ☐ (P)upils ☐ (E)OM
☐ (C*)onjunctiva/Eyelids ☐ Rt ☐ Lt ☐ Botl
☐ (S*)clera/Cornea/Iris ☐ Rt ☐ Lt ☐ Botl
☐ (F*)undusopic ☐ Rt ☐ Lt ☐ Botl
☐ (O*)ther, specify:

Concise Comments(+): Arcus senilis

EARS Check:
(ERX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/EXB-)

- ☐ (E*)xternal Ear ☐ Rt ☐ Lt ☐ Both
☐ (C*)anals, External ☐ Rt ☐ Lt ☐ Both
☒ (T*)ympani ☒ Rt ☐ Lt ☐ Both

☒ (O*)ther, specify: Slight hearing loss
Concise Comments(+): Tympani - scar from ruptured eardrum

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAMINATION FINDINGS**

P E X

NOSE Check:
(NX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/NB-)

☐ (E)xternal ☐ (O*)ther, specify:

☐ (M)ucosa _____

Concise Comments(*): _____

ORAL CAVITY Check:
(MX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/MB-)

☐ (L)ips ☐ (P)harynx

☐ (G)ums or Teeth ☐ P(a)late

☐ (M)outh ☐ (O*)ther, specify:

☐ (B)reath _____

☐ (T)ongue Concise Comments(*): _____

NECK Check:
(NKX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/NKB-)

☐ (M)uscles ☐ T(r)achea

☐ (S)pine ☐ (C)arotid Arteries

☐ (T)hyroid ☐ (O*)ther, specify:

☐ (L)ymph Nodes _____

Concise Comments(*): _____

THORAX AND LUNGS Check:
(TLX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/TLB-)

☐ (T)horacic Wall (masses, pain, tenderness,
crepitus or other)

☐ (R)ales (Crackles) ☐ (O*)ther, specify:

☐ (W)heezes _____

Concise Comments(*): _____

FEMALE BREAST Check:
(BRX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, describe:
(A/BRB)

HEART Check:
(HX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/HXB-)

☒ (M)urmur(s) ☐ (P)alpation (Thrill)

☐ (R)hythm ☐ (O*)ther, specify:

☐ (H)eart Sounds _____

Concise Comments(*): _____

AXILLAE Check:
(AXL-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, describe: (A/AX-)

OCCUPATIONAL HEALTH CARE
PHYSICAL EXAMINATION FINDINGS

P E X

ABDOMEN Check:
(ABX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/ABB-)

- ☐ B(r)uits ☐ (B)owel Sounds
☐ (M)ass ☐ (T)enderness
☐ (L)iver ☐ (O*)ther, specify:
☐ (S)pleen

Concise Comments(*):

FEMALE GENITALS Check:
(FGX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/FGB-)

- ☐ (E)xternal Genitalia ☐ (H)ernia
☐ (S)peculum Exam ☐ (O*)ther, specify:
☐ (P)alpation

Concise Comments(*):

MALE GENITALS Check:
(MGX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/MGB-)

- ☐ (P)enis ☐ (H)ernia
☐ (T)esticles ☐ (O*)ther, specify:

Concise Comments(*):

RECTAL Check:
(REX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☒ (R)efused

If any ABNORMALITIES, specify where:
(A/REB-)

- ☐ (A)nus ☐ (H)emoccult Positive
☐ (M)ass ☐ (O*)ther, specify:
☐ (P)rostate

Concise Comments(*):

BACK Check:
(BX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/BB-)

- ☐ (S)pine Palpation ☐ (O*)ther, specify:
☐ (R)ange of Motion

Concise Comments(*):

EXTREMITIES AND JOINTS Check:
(EJX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/EJB-)

- ☐ (H)and ☐ (S)houlder ☐ (L)ower Leg
☐ Fi(n)gers ☐ H(i)p ☐ (A)nkle
☐ (W)rist ☐ Thi(g)h ☐ (F)oot
☐ Fo(r)earm ☐ (K)nee ☐ (T)oes
☐ (E)lbow ☐ (O*)ther, specify:

Concise Comments(*):

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAMINATION FINDINGS**

P E X

NEUROPSYCHIATRIC *Check:*

(NPX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/NPB-)

- ☐ (M)ental Status ☐ (R)omberg
- ☐ Cranial (N)erves ☐ (B*)ehavior, specify: _____
- ☐ (C)oordination _____
- ☐ (G)en Motor Response _____
- ☐ (D)eep Tendon Reflexes
- ☐ (S)ensory Testing Gen.
- ☐ (O*)ther, specify: _____

Concise Comments(*): _____

OTHER FINDINGS

(OTX)

Concise Comments: Physically fit for
continued employment.

VASCULAR SYSTEM *Check:*

(VX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/VB-)

- ☐ (C)arotid Pulses
- ☐ (B)rachial Pulses
- ☐ (R)adial Pulses
- ☐ (A)bdominal Aorta Pulses
- ☐ (F)emoral Pulses
- ☐ (P)opliteal Pulses
- ☐ (D)orsalis Pedis Pulses
- ☐ Posterior (T)ibial Pulses
- ☐ (V)aricosities
- ☐ (O*)ther, specify: _____

Concise Comments(*): _____

PROBLEM LIST

If appropriate, indicate special status with a letter before the slash

☐

NO

PROBLEMS

(I = Inactive, H = History of, R = Rule Out, P = Presumptive,
Y = Status Post, M = Major, S = Short Duration)

(ICD-9-CM)

H / Hypertension	(401
H / Coronary Disease	(414
/ Hearing Loss - High Freq. Slight	(389
I / Hemorrhoids - 1979	(455
/	(
/	(
/	(
/	(
/	(

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAMINATION FINDINGS**

P E X

DISPOSITION Check ALL that apply. (DSP-)

- ☒ (A) Full work/duty
- ☐ (B) Send home/sick in quarters
- ☐ (C) Admit to hospital
- ☐ **RESTRICTION(S)** (If restricted, check ALL that apply.)
- ☐ (D) Lifting, pushing, pulling or carrying
- ☐ (E) Climbing, working at heights, driving gov't vehicle or working around dangerous machinery
- ☐ (F) Noise or vibration
- ☐ (G) Bending, twisting or awkward positions
- ☐ (H) Dust, fumes, smoke or gases
- ☐ (I) Walking, standing or foot hazardous areas
- ☐ (J) Crawling, kneeling or squatting
- ☐ (K) Chemicals, solvents, greases, oils
- ☐ (L) Other Restriction (Specify) _____

☐ **REFERRAL** If the patient is referred to a specialty clinic, ER or private doctor, check the appropriate box(es) below.

TYPE OF REFERRAL	CLINICS					
	Ophthal- mology	Emer. Room	Cast Room/ Orthopeds.	Derma- tology	Otolar./ Audio!	Other (Specify)
Refer to NAVHOSPSANDIEGO the same day	(M)	(N)	(O)	(P)	(Q)	(R)
Refer to NAVHOSPSANDIEGO another day	(S)	(T)	(U)	(V)	(W)	(X)
Refer to civilian medical facility the same day	(Y)	(Z)	(Ø)	(1)	(2)	(3)
Refer to civilian medical facility another day	(4)	(5)	(6)	(7)	(8)	(9)

NHRC [11-30-84]

The data collected on an Encounter Form are divided into two parts---the HEADER and the BODY. The Header contains primarily administrative information that identifies the patient, the date and site of the encounter, and the nature of the visit and service provided. A double line marks where the Header information ends on the Encounter Form. The Body of the Encounter Form begins right after the double line and is used to collect work and medical information. The distinction between the Header and the Body of an encounter is preserved when the record of the encounter is retrieved for display or printout.

Now, let's try entering the encounter data for a scheduled physical exam as shown in Exhibit 2. At the Enter Medical Data Option prompt, enter E to select ENCOUNTER entry. NOHIMS then will prompt for the name of the patient whose encounter data are to be entered as shown below. REMEMBER, you cannot enter any encounter or history data unless the patient has been registered in NOHIMS.

```
ENTER MEDICAL DATA OPTION > ENCOUNTER
ENTER ENCOUNTER FOR PATIENT > GR,J;M;
```

1 GREELEY,JAMES C

M 7/14/50

061-32-7684

P

Is this the patient <Y>

We can enter either the patient's name, sex, and date of birth or the patient's social security number to identify the patient. We used the rapid method of identifying the patient whose encounter data we wish to enter. NOHIMS finds a patient that matches the characters we have entered in response to the ENTER ENCOUNTER FOR PATIENT prompt and then asks us, Is this the patient? The default response is Yes. If we are satisfied that this is the patient we want, then we simply press RETURN. NOHIMS then prompts for the DATE OF ENCOUNTER. We can use the T convention explained in Paragraph 15 of Section 2. If the Date of the Encounter is Today, simply enter T. If the Date of the Encounter is Yesterday, enter T-1. However, the Date of the Encounter shown in Exhibit 2 is September 26, 1984. We would enter the date in MM/DD/YY format as shown below. We can omit the year, and NOHIMS will provide the last two digits of the current year automatically.

```
DATE OF ENCOUNTER > 9/26/84
```

```
PROVIDER 1 > REED,WALTER,MD; OCCUPATIONAL HEALTH PHYSICIAN
```

```
PROVIDER 2 > NIGHTINGALE,FLORENCE,RN; OCCUPATIONAL HEALTH NURSE
```

```
PROVIDER 3 >
```

After we entered the date, NOHIMS prompted for PROVIDER 1. We entered the first two letters of the last name of Provider No. 1 on the PEDS/PEX Encounter Form. Enter enough letters of the provider's last name to uniquely

identify him or her. NOHIMS then prompts for PROVIDER 2. If a second provider's name has been written on the PEDS/PEX Encounter Form, then that provider would be entered in response to the PROVIDER 2 prompt. If there is no name entered for Provider No. 2, then simply press RETURN. However, if you enter a name at the PROVIDER 2 prompt, NOHIMS will prompt for PROVIDER 3. Ignore this prompt by pressing RETURN.

Next NOHIMS prompts for SITE Code, TYPE of Examination Code, and VISIT CLASSIFICATION as shown below.

SITE > A NORTH ISLAND
TYPE > F PERIODIC EXAM

VISIT CLASSIFICATION > 1 CIVILIAN SCHEDULED PHYSICAL EXAM

PATIENT: GREELEY, JAMES C
DATE OF ENCOUNTER: 9/26/84
PROVIDERS: REED, WALTER, MD
 NIGHTINGALE, FLORENCE, RN
SITE: NORTH ISLAND
TYPE: PERIODIC EXAM

VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM

FILE, EDIT, OR IGNORE >

We entered the codes checked on the PEDS/PEX Encounter Form for the SITE, TYPE, and VISIT CLASSIFICATION. We could have entered ^L at each of these prompts to see a list of the possible code selections before entering the code actually checked on the PEDS/PEX Encounter Form. When the last item of HEADER data has been entered, NOHIMS displays a complete list of all of the data items in the Header for your review of everything that has been entered in the encounter up to this point. If the entries are correct, you may file the data by entering an F for FILE. If you see an error, enter an E to edit your responses. NOHIMS will display each data item in the Header for you to review and/or correct. For our first example encounter, let's suppose we found no errors; so the Header data are accepted for filing as displayed.

FILE, EDIT, OR IGNORE > F

>>>

Notice the new prompt that appears after the Header data have been filed ---a triple caret (>>>). This prompt signals you that NOHIMS is now looking for the entry of work and medical information. The triple caret prompt also

reminds you that the procedures for entering data items now are somewhat different. Also, after you reach the triple caret prompt, NOHIMS gives you more time to respond before timing out. But before NOHIMS times out, you will receive the prompt ENCOUNTER COMPLETE? Entering N for No prevents NOHIMS from timing out and allows you more time to complete entering all of the encounter data. Before we begin entering the work and medical data items at the triple caret prompt, the various methods for entering these data will be described.

Medical and work data must be entered in the following sequence:

STATUS/CODE-MODIFIER*FREE TEXT

STATUSes may be attached to medical data Codes to clarify the meaning of the Code. For example, a STATUS may add information such as the intensity or duration of a condition, it may indicate whether an old diagnosis is inactive, or it may instruct NOHIMS how to use the medical data item in reports.

The CODE portion of the medical data entry sequence corresponds to the letter Code shown in parentheses after each medical data item where only one check mark is allowed, or before each medical data item where the occupational health care provider is instructed to check all possibilities that apply. The CODE is tied to the full name of the medical data item and makes data entry easier.

MODIFIERS are descriptive terms that have been added to many of the Codes for medical data items in order to amplify their meaning. In some cases, multiple modifiers can be entered, as with DISPOSITION for example.

The ASTERISK (*) at medical entry time signals NOHIMS that you want to enter any free text or comments associated with a Code. There are certain NOHIMS Codes where you do not need to use the * because they automatically prompt for a related textual comment. DISPOSITION is one example of not having to enter an asterisk to trigger NOHIMS to prompt for free text.

Now let's proceed with entering the work and medical data items for the PEDS/PEX Encounter Form shown in Exhibit 2. The first section of the PEDS/PEX Encounter Form after the double line which marks the end of the Header and the beginning of the Body of the Encounter is the Work Information section. The first data item is the patient's Job Title, shown in Exhibit 2 as A/C Engine Mechanic. This information must be entered as free text. Therefore, NOHIMS prompts for text as shown below. You enter the Code JT at the first triple caret prompt, press RETURN, and then enter A/C ENGINE MECHANIC at the 1> prompt.

```
>>> JT
      ASAC7 JOB TITLE
1> A/C ENGINE MECHANIC
2>
```

Note that when you enter JT at the first triple caret prompt and press RETURN, NOHIMS displays the internal code ASAC7 it uses to store this item and also the full name of the item. When you press RETURN after typing A/C ENGINE MECHANIC at the first line of free text, NOHIMS then prompts for a second line of text. Ignore this prompt by simply pressing RETURN. When you press RETURN at the 2> prompt, NOHIMS returns with the triple caret prompt so that you can enter the next data item.

There are four more items of WORK INFORMATION as shown in Exhibit 2---Work Supervisor, Building Number, Shop Number, and Shop Telephone. The information written on the PEDS/PEX Encounter Form for these four data items also must be entered as free text. Let's try entering all four of them consecutively.

```
>>>  WS
      ASBM1  WORK SUPERVISOR
1>  SMITH,MARK
2>

>>>  BLDG
      ASBK4  BUILDING NUMBER
1>  32415
2>

>>>  SHN
      ASAK8  SHOP NUMBER
1>  95222
2>

>>>  SHT
      ASBC3  SHOP TELEPHONE NUMBER
1>  437-4821
2>
```

There is one remaining data item on the first page of the PEDS/PEX Encounter Form---the Form Control Number (FCN) which appears in the lower right-hand corner of the page. This number is entered as text and should be entered next as shown below.

```
>>>  FCN
      ARAB4  FORM CONTROL NUMBER
1>  103
2>
```

We now have completed data entry for the first page of the PEDS/PEX Encounter Form. The first section on the second page of the PEDS/PEX Encounter Form involves JOB CERTIFICATION. The Code for this data item is JC

as shown in parentheses on the PEDS/PEX form. The provider is instructed to check only one of the 11 possible choices shown on the form. The letters in parentheses to the left of each choice correspond to the Modifiers that have been added to the JC Code to amplify its meaning. If the provider checks Modifier 0 (for Other), the name of the job should be specified on the form and entered as free text. Your data entry would be JC-0*, with the job specified entered as free text at the 1> prompt. In Exhibit 2 the provider has checked that this physical exam is for job certification for Aircraft Handler. Your data entry for this medical item should be JC-G as shown below.

>>> JC-G
BBAK1-G PHYSICAL EXAM IS FOR JOB CERTIFICATION (FOR AIRCRAFT HANDLER)
STATUS: NORMAL

When you enter JC-G at the triple caret prompt and press RETURN, NOHIMS displays the internal code (BBAK1-G) it uses to store this combination of data item plus Modifier and also the full name of the item. Note that the Modifier is displayed within parentheses after the full name of the data item. NOHIMS then returns with the triple caret prompt so that you can enter the next data item.

The other section on the second page of the PEDS/PEX Encounter Form concerns HAZARDOUS AGENT SURVEILLANCE. In this section the occupational health care provider is instructed to check ALL hazards that apply. Three hazards have been checked on the PEDS/PEX Encounter Form shown in Exhibit 2. The Code shown to the left of each hazard is used for data entry. Let's enter the three hazards checked using the corresponding Codes.

>>> ASB
BBAQ5 HAZARD SURV ASBESTOS
STATUS: NORMAL

>>> MRC
BBAN8 HAZARD SURV MERCURY Inorganic
STATUS: NORMAL

>>> NS
BBBF3 HAZARD SURV NOISE
STATUS: NORMAL

Note here that NOHIMS automatically assigns a STATUS of NORMAL to these three Hazardous Agent Surveillance data items unless an Abnormal Status Code is entered preceding the Code checked on the form. Surveillance for a hazardous agent other than for those appearing on the PEDS/PEX Encounter Form can be specified by a provider on the HSO Other line. When a provider writes in a hazardous agent on the HSO Other line, check your job aid for Other Hazardous Agents to look for a match. If you find it on the job aid, use the code corresponding to the hazard to make a correct data entry. If you cannot

find the hazardous agent on the job aid, then you will have to enter it as free text. In this case your data entry would be HSO, with the hazardous agent specified entered as free text at the 1> prompt.

The first section on the third page of the PEDS/PEX Encounter Form is PROTECTIVE EQUIPMENT. In this section the occupational health care provider is instructed to check ALL that apply. In the example shown in Exhibit 2, the provider did not check any of the choices, so you may go to the section which follows PROTECTIVE EQUIPMENT.

LABORATORY TESTS is the next section on the PEDS/PEX Encounter Form. In this section the occupational health care provider is also instructed to check ALL possibilities that apply. The provider has ordered four laboratory tests as shown in Exhibit 2. The Code shown to the left of each test is used for data entry. Let's enter the four tests checked using the corresponding Codes.

>>> SMCB
WRFV4 SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY

>>> UA
WNBQ1 URINALYSIS

>>> CBC
MNAA2 COMPLETE BLOOD COUNT

>>> DFF
WRDR5 DIFFERENTIAL WITH MORPHOLOGY

Note that there are several places at the bottom of the LABORATORY TESTS section where the provider can specify other tests to be ordered. There is room on the PEDS/PEX Encounter Form to specify a Heavy Metal Ion test other than those already appearing on the form. There is also room to specify two other chemistry tests as well as two other lab tests. However, the most commonly ordered Laboratory Tests are those that appear on the PEDS/PEX Encounter Form. To help you determine the proper Code to enter for Other data items specified by providers, consult the NOHIMS job aid that lists the Codes for other laboratory tests. If you come across an Other data item that is not listed in this job aid, call your NOHIMS System Manager to find out what Code to use. When you learn what the proper Code is, add it to the list in the job aid so you will know how to enter this data item in the future.

The next section on the third page of the PEDS/PEX Encounter Form is RADIOLOGY. Three types of Chest Xrays appear on the form since these are the most commonly ordered Xrays for scheduled physical exams. However, other Xrays may also be ordered. Consult the NOHIMS job aid for a list of Other Xrays that may be specified by providers to determine the proper Code to use for data entry. In Exhibit 2 the provider has ordered a Chest Xray for Asbestos. We would enter this data item as shown below.

>>> CSB
SNAD1 CHEST XRAY ASBESTOS

The next section on the PEDS/PEX Encounter Form is PULMONARY FUNCTION TESTS. The reason for ordering Pulmonary Function Testing may be for Asbestos monitoring or for Other than Asbestos monitoring. In the example PEDS/PEX Encounter Form shown in Exhibit 2, Pulmonary Function Testing was ordered for Asbestos monitoring. Data entry should look as follows for this data item.

>>> PFTA
WQFT1 PULMONARY FXN TEST ASBESTOS

Note next that the provider did not order an electrocardiogram. Therefore, you may skip to AUDIOMETRY.

In the AUDIOMETRY section of Exhibit 2, the provider has checked Excessive Noise Exposure as the reason for the audiogram. This data item should be entered as shown below.

>>> ENX
WRGK2 AUDIOGRAM FOR EXCESSIVE NOISE EXPOSURE

The last section on the third page of the PEDS/PEX encounter Form is EYE EXAMINATION. If an eye examination is to be done by the Optometry Department, the box in this section will be checked. If it is checked, this information is not entered into NOHIMS.

There is a short header on the fourth page of the PEDS/PEX Encounter Form showing the patient's social security number and the name of the physician providing the exam so that the back part of this form can be properly matched with the front part in case they become separated for any reason. A double line marks the end of this brief header. You do not re-enter this header data but only use it to verify that you are continuing to enter medical data for the same patient.

The next data item to be entered at the triple caret prompt is PHYSICIAN EXAMINATION. In the example shown in Exhibit 2, a Full Physician Exam was checked. Data entry should look as follows for this data item.

>>> FPE
BFAY1-F FULL PHYSICIAN EXAMINATION
STATUS: NORMAL

HEIGHT, WEIGHT, and VITAL SIGNS are entered next as shown below.

```
>>> HT
      CAJCI HEIGHT
ENTER HEIGHT > 69

>>> WT
      CAKHI WEIGHT
ENTER WEIGHT > 215

>>> TMP
      CACVI TEMPERATURE
ENTER TEMPERATURE > 98.4

>>> PLS
      CADAI PULSE
ENTER PULSE > 78

>>> RR
      CAFLI RESPIRATORY RATE
ENTER RESPIRATORY RATE > 18

>>> BP
      CAEFI BLOOD PRESSURE

BLOOD PRESSURE > 150/92
MODIFIER >
BLOOD PRESSURE >
<ABNORMAL>
STATUS: ABNORMAL
```

After NOHIMS prompts for Blood Pressure the first time, it allows you to enter a Modifier specifying which arm or leg was used and whether the patient was standing, sitting, or lying. However, this information is not recorded under VITAL SIGNS, so you may ignore the Modifier prompt by pressing RETURN. NOHIMS then prompts for Blood Pressure again in case a second measurement has been recorded on the encounter form. Typically there will be only one blood pressure measurement, and you will press RETURN at the second Blood Pressure prompt. NOHIMS then indicates whether the Blood Pressure entered is considered NORMAL or ABNORMAL. In the example in Exhibit 2, the blood pressure recorded is 150/92, which is considered abnormally high by NOHIMS. Press RETURN to accept the Status that NOHIMS assigned.

We now move on to GENERAL APPEARANCE. In Exhibit 2, the physician checked the NORMAL box but also wanted to note that the patient appeared obese, although the patient's obesity was not considered an abnormality. The correct way to enter this data item is as follows. Note that the Code to use is located just beneath GENERAL APPEARANCE in parentheses. You must also enter the Modifier N for NORMAL and an asterisk (*) to cause NOHIMS to prompt for text.

>>> GAX-N*
CBAM1-N GENERAL APPEARANCE WAS NORMAL
STATUS: NORMAL
1> OBESITY
2>

Following the example shown in Exhibit 2, the next data item is SKIN and should be entered as follows. The Code to use for data entry of physical examination findings always appears just below the name of the data item.

>>> SKX-N
GBAW1-N SKIN EXAMINATION WAS NORMAL
STATUS: NORMAL

The physician considered the examination of the patient's EYES to be NORMAL but recorded Arcus Senilis as a finding, although this was not noted as an abnormality. Remember to enter an asterisk after the Code and Modifier so that NOHIMS will prompt for a textual entry.

>>> EYX-N*
HBAJ9-N EYES EXAMINATION WAS NORMAL
STATUS: NORMAL
1> ARCUS SENILIS
2>

The physician wrote down several findings for the EAR EXAMINATION under the ABNORMALITIES section of EARS. The patient has a slight hearing loss and a scar from a ruptured eardrum in the right tympani. The Code for an abnormal finding is located beneath ABNORMALITIES in parentheses. When entering an abnormal finding, you must enter a Status Code of A followed by a slash in front of the main Code to change the STATUS to ABNORMAL. You must also enter the Modifier(s) of the abnormality location(s) and an asterisk (*) to cause NOHIMS to prompt for text, if any, after the main Code. The entry for this patient's EAR EXAMINATION would be as shown below.

>>> A/EXB-TO*
JBAY4-TO EAR EXAMINATION WAS ABNORMAL (TYMPANI) (OTHER EARS)
STATUS: ABNORMAL
1> TYMPANI-RIGHT. SCAR FROM RUPTURED EARDRUM. OTHER-SLIGHT HEARING LOSS.
2>

The Modifiers for the abnormality locations should be entered in the order that they appear on the form. Therefore, we entered the Modifiers as TO rather than OT. Enter Modifiers in the first column before those in the second column if there are two columns of Modifiers for a Code. To enter the comments, we first typed the location of the first abnormality (TYMPANI),

followed by a hyphen and the comments separated by a period and a single space (RIGHT. SCAR FROM RUPTURED EARDRUM.). Note that we put two spaces between the comments and the next abnormality location.

The examination of the patient's NOSE, ORAL CAVITY, NECK, and THORAX AND LUNGS were all considered NORMAL, and should be entered as shown below.

>>> NX-N
JBAH2-N NOSE EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> MX-N
JBAQ3-N ORAL CAVITY EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> NKX-N
VBAX1-N NECK EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> TLX-N
LBAE1-N THORAX AND LUNGS EXAMINATION WAS NORMAL
STATUS: NORMAL

Since the patient in the example shown in Exhibit 2 is a male, the FEMALE BREAST and FEMALE GENITALS (next page of the PEX) data items are not applicable to this patient and, therefore, are not entered.

The next examination is the HEART. The patient has a heart murmur. This finding should be entered as shown below. Since the physician did not enter any comments on the form, we do not need to enter an asterisk after the Code. We should, however, enter the Status Code before the main Code in order to change the STATUS to ABNORMAL.

>>> A/HXB-M
MBAP2-M HEART EXAMINATION WAS ABNORMAL (MURMUR OR MURMURS)
STATUS: ABNORMAL

The physician examined the patient's AXILLAE, ABDOMEN, MALE GENITALS, BACK, EXTREMITIES AND JOINTS, NEUROPSYCHIATRIC status, and VASCULAR SYSTEM next, finding all of them to be NORMAL. The patient refused the RECTAL examination. Correct data entry for these eight items is shown below.

>>> AXL-N
PBAT2-N AXILLAE EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> ABX-N
QBAN1-N ABDOMEN EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> MGX-N
SBAS1-N MALE GENITALS EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> REX-R
QBAW2-R RECTAL EXAMINATION WAS REFUSED
STATUS: NORMAL

>>> BX-N
VBAE2-N BACK EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> EJX-N
VBAM3-N EXTREMITIES AND JOINTS EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> NPX-N
WBAZ1-N NEUROPSYCHIATRIC EXAMINATION WAS NORMAL
STATUS: NORMAL

>>> VX-N
NBAJ1-N VASCULAR SYSTEM EXAMINATION WAS NORMAL
STATUS: NORMAL

Under OTHER FINDINGS, the physician has noted that the patient is considered "Physically fit for continued employment." This is an example of a Code for which NOHIMS automatically prompts for text because the only time the Code would be entered is if there were comments to enter. This data item should be entered as follows.

>>> OTX
CBAV2 OTHER FINDINGS
STATUS: NORMAL
1> PHYSICALLY FIT FOR CONTINUED EMPLOYMENT.
2>

Under the PROBLEM LIST, the physician has recorded four problems and used Status Codes with three of the problems for further clarification (H for HISTORY OF and I for INACTIVE). You will have to look up these problems in the ICD-9-CM (International Classification of Diseases) manual to identify the appropriate 3-digit ICD-9-CM code to write on the PEDS/PEX Encounter Form. In the example shown in Exhibit 2, the data entry clerk has already looked up the four problems in the ICD-9-CM manual and written the corresponding codes on the encounter form. Actually, before you begin data entry for a PEDS/PEX Encounter Form, you should turn to the PROBLEM LIST page to see if the physician has recorded any problems. If so, you should look up the ICD-9-CM code(s) and write them on the encounter form at that time so that you will not have to stop during your data entry sequence to do this look-up.

The most common problems seen at the Occupational Health Unit have been listed in a NOHIMS job aid along with their corresponding 3-digit ICD-9-CM codes. The ICD-9-CM codes have been entered in NOHIMS as the abbreviated or short name for problems listed in the manual. As a result, you may enter the ICD-9-CM code, and NOHIMS will find the corresponding problem. If you come across a problem that is not on the job aid, add it to the list along with the 3-digit ICD-9-CM code that you find in the manual. This way you will build a list of all problems seen at the Occupational Health Unit.

There is also a job aid consisting of ICD-9-CM V codes which are entered in NOHIMS when appropriate. These are problem codes covering persons with special personal or family histories or conditions influencing their health status.

If the physician's description of the problem is more specific or contains more information than the NOHIMS Code name, enter an asterisk after the Code to cause NOHIMS to prompt for text. At the 1> prompt, enter the more specific description or additional information. The NOHIMS name is the same as the name of the 3-digit code in the ICD-9-CM manual. The four problems shown in Exhibit 2 should be entered as follows.

```
>>> H/401
      FLBG8  HYPERTENSION
STATUS: HISTORY OF
```

```
>>> H/414*
      MLBX5  OTHER FORMS CHRONIC ISCHEMIC HEART DISEASE
STATUS: HISTORY OF
1> CORONARY DISEASE
2>
```

```
>>> 389*
      JLAQ9  HEARING LOSS
1> HIGH FREQ. SLIGHT
2>
```

```
>>> I/455*
      NLCX4  HEMORRHOIDS
STATUS: INACTIVE
1> 1979
2>
```

The last page of the PEDS/PEX Encounter Form is for recording DISPOSITION. In Exhibit 2 the physician checked Modifier A for Disposition, so your data entry should be DSP-A as shown below.

```
>>> DSP-A
      AACQ1-A DISPOSITION FULL WORK OR DUTY
A. FULL WORK OR DUTY
1>
```


When you enter DSP-A and press RETURN, NOHIMS displays the internal Code (AACQ1-A) it uses to store this combination of data item plus Modifier and also the full name of the item. Note that the Modifier is displayed after the name of the data item. DISPOSITION is one of the NOHIMS Codes where you are automatically prompted for a related textual comment. If the provider has written in any comments regarding Disposition, they should be entered at the 1> prompt. NOHIMS will prompt for a second line of text if the comments exceed the capacity of the first line. If the provider checks Modifier L (for Other Restriction), the Restriction should be specified on the form and entered as free text at the 1> prompt. If the provider checks Modifier R, X, 3, or 9 (Other Referral), the place referred to should be specified on the form and entered as free text at the 1> prompt.

If more than one disposition is checked, all of the Modifiers should be entered after the Code. For example, if the provider selected both F and G, the data entry would be DSP-FG. Always enter the Modifiers in alphabetical order.

When you complete data entry for the DISPOSITION section on the PEDS/PEX Encounter Form, you have finished data entry for this encounter. NOHIMS will return with another triple caret prompt, allowing you to re-enter any data item that may have an error or be incomplete. Sometimes while entering data you will discover that you forgot to enter a modifier, status, or the free text associated with a code. It is easy to correct these entries either at the time you notice the error or at this point, just after finishing the encounter. When you re-enter any data item that may have an error or missing information, your new entry and its associated data (status, modifier, or text, if any) will replace your previous entry.

For example, let's say that you wanted to enter the code for Diabetes Mellitus (ICD-9-CM Code 250) with a status of R for Rule Out and the free text comment of "Patient complains of excessive thirst and nocturia," but you forgot to put the R in front of 250 and made a typographical error in the free text entry. You can correct this entry by simply re-entering the information properly as follows.

```
>>> 250*
      ELAJ6 DIABETES MELLITUS
1> PT C/O EXCESSIVE THIRST AND NOCTURIA.
2>

>>> R/250*
      ELAJ6 DIABETES MELLITUS
STATUS: RULE OUT
1> PT C/O EXCESSIVE THIRST AND NOCTURIA.
2>

>>>
```

(Wrong entry. No status was stored. There is a typographical error in the stored free text.)

(Correction entry. The status has now been stored with the code and the corrected text has replaced the text with the error.)

If you entered just R/250 at the second entry, the status would be stored in the patient's record along with the code, but there would no longer be any free text comment stored with the code.

If you entered a wrong data item by mistake, you must use the ERROR Status Code to flag your wrong entry as an error and to stop it from displaying or printing in any NOHIMS reports. Let's suppose we had accidentally entered the Code CDM and we want to correct our mistake. Our correction would look as follows.

```
>>>  E/CDM
      BDDR3  HAZARD SURV CADMIUM
*** BDDR3 FLAGGED AS ERROR ***
```

```
>>>
```

When you press RETURN at the last triple caret prompt after making no entry, NOHIMS will ask you if the encounter is complete. If you enter Y for Yes, then NOHIMS will prompt for the encounter data for another patient as shown below.

```
>>>
ENCOUNTER COMPLETE ? Y
ENTER ENCOUNTER FOR PATIENT >
```

Assuming that you have batched all PEDS/PEX Encounter Forms for the day, to be entered at the end of that day or first thing the next day, you now can proceed to enter the encounter data for another patient. However, if you are finished entering encounters, you may use the ^ command to select another ENTER MEDICAL DATA option such as LAB RESULTS or MEDICAL EDIT, or use the ^ command more than once to move on to another primary system option or to EXIT from NOHIMS.

ENCOUNTER ENTRY - PERIODIC HEALTH EVALUATION---NAVY ASBESTOS MEDICAL
SURVEILLANCE PROGRAM (NAVMED 6260/5)

Another type of Encounter Form which is used in NOHIMS is the Periodic Health Evaluation---Navy Asbestos Medical Surveillance Program Form (6260/5). An example of this 1-page form is shown in Exhibit 3. The 6260/5 is used in addition to the PEDS/PEX Encounter Form. It records patient data collected specifically for the Navy Asbestos Medical Surveillance Program.

The example of the 6260/5 shown in Exhibit 3 contains typical data that might be collected during a scheduled asbestos physical examination for a civilian employee at the Naval Air Rework Facility. Because the form was designed by the Navy Asbestos Medical Surveillance Program, it is formatted differently than the PEDS/PEX Encounter Form. A plastic overlay, included with this manual, is used to make the 6260/5 compatible with NOHIMS entry. Exhibit 4 is the example 6260/5 from Exhibit 3 with the overlay photocopied onto it. When you are doing entry of a 6260/5, you should place the plastic overlay on top of the patient's 6260/5 form.

As we explained in the previous section on the PEDS/PEX Form entry, we enter encounter data in two parts---the HEADER and the BODY. The Header information for the 6260/5 encounter is found in the three rows of boxes at the top of the form, above "Respiratory Questionnaire" and "Respiratory Physical Examination." The Body information is found in the Questionnaire and Physical Examination portions of the form.

Now, let's try entering the encounter data for the asbestos physical examination shown in Exhibit 4. At the Enter Medical Data Option prompt, enter E to select ENCOUNTER entry. NOHIMS will then prompt for the name of the patient whose asbestos physical examination is to be entered as shown below. REMEMBER, you cannot enter any encounter or history data unless the patient has already been registered in NOHIMS.

ENTER MEDICAL DATA OPTION > ENCOUNTER
ENTER ENCOUNTER FOR PATIENT > GR,J;M;7/14/50

1 GREELEY,JAMES C M 7/14/50 061-32-7684 P

Is this the patient? <Y>

The name, sex, and date of birth used to identify the patient can be found in the boxes marked 1, 2, and 3 on the overlay. You may use either the rapid method of identifying the patient or the standard method. If you are satisfied that this is the patient you want, then simply press RETURN. NOHIMS then prompts for the DATE OF ENCOUNTER. We can use the T convention explained in Paragraph 15 of Section 2. The date is found in box 4 on the overlay.

PERIODIC HEALTH EVALUATION

NAVY ASBESTOS MEDICAL SURVEILLANCE PROGRAM

Sections 133, 1071-47, 3012, 5031 and 8012 Title 10 USC & Exec. Order 9397 (Privacy Act of 1974) Apply

USE HARD TIPPED PEN & PRESS FIRMLY, LEGIBLE COPY REQUIRED FOR DATA ENTRY

RETAIN ORIGINAL IN HEALTH RECORD SEND COPY TO Commanding Officer NAVY ENVIRONMENTAL HEALTH CENTER Naval Station, Norfolk, Virginia 23511	EXAMINATION FACILITY NAME UIC 	PAGE 1 of 1 CONTROL NUMBER (For NEHC Use Only)
--	---	--

NAME (LAST) GREELEY	(FIRST) JAMES	(M.I.) C	SOCIAL SECURITY NO. 0 6 1 3 2 1 6 8 4
-------------------------------	-------------------------	--------------------	--

DATE OF BIRTH (DAY) 0 1 (MO) 1 4 (YR) 5 0	RACE (Check One) <input type="checkbox"/> White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian <input type="checkbox"/> Other	STATUS (Check One) <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input checked="" type="checkbox"/> Civilian	OCCUPATIONAL CODE (Civilian Employees) 	GRADE/RATE (Military)
SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	YRS. GOV'T. SER. 	EXAM PURPOSE (Check One) <input type="checkbox"/> INITIAL <input checked="" type="checkbox"/> PERIODIC <input type="checkbox"/> TERMINATION	SHIPBOARD PERS. ONLY ENTER SHIP HULL NO. 	
TODAY'S DATE (DAY) 0 9 (MO) 2 6 (YR) 8 4				

RESPIRATORY QUESTIONNAIRE	RESPIRATORY PHYSICAL EXAMINATION
1. Are you currently working directly with asbestos in your job? (within the last year) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7. Weight (in pounds) 2 1 5
2. A. Was/is your exposure on a regular basis? (15 days per quarter or 45 days per year) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> B. How many years? (check one) Less than one <input type="checkbox"/> More than one; less than five <input checked="" type="checkbox"/> More than five; less than fifteen <input type="checkbox"/> More than fifteen <input type="checkbox"/>	Height (in inches) 6 9
C. How old were you when first exposed? 2 2	8. Appearance A. Stature Normal <input type="checkbox"/> Obese <input checked="" type="checkbox"/> B. Chest Configuration Normal <input checked="" type="checkbox"/> Increased A-P diameter <input type="checkbox"/> Other chest deformity <input type="checkbox"/> C. Clubbing None <input checked="" type="checkbox"/> Present <input type="checkbox"/>
3. Do you usually have or have you usually had the following? (Usually means more than a quarter of the time.) A. Cough <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> B. Phlegm <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> C. Wheezing <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> D. Shortness of breath <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	9. Crackles None <input type="checkbox"/> Localized late inspiratory <input type="checkbox"/> Bilateral late inspiratory <input type="checkbox"/> Localized early inspiratory <input checked="" type="checkbox"/> Bilateral early inspiratory <input type="checkbox"/>
4. Do you now or have you ever smoked cigarettes? (If no, skip to question 5.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> A. If so, what age did you begin? 1 5 B. How much do you/did you smoke? (on average) Less than one pack per day <input type="checkbox"/> One pack per day <input checked="" type="checkbox"/> More than one pack per day <input type="checkbox"/> More than two packs per day <input type="checkbox"/> C. If you have quit, at what age did you do so? 	10. Wheezes None <input checked="" type="checkbox"/> Single or multiple monophonic wheezes <input type="checkbox"/> Polyphonic expiratory wheezes <input type="checkbox"/> Short late inspiratory, monophonic wheeze associated with inspiratory crackles <input type="checkbox"/>
5. Do you smoke a pipe or cigars? (If no, skip to question 6.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> A. How many years have/did you smoke a pipe or cigars? 	11. Spirometry (note decimal point) FVC observed (BTPS) in liters 3 4 2 FEV1 observed (BTPS) in liters 3 1 5
6. Have you ever had a serious lung disease requiring hospitalization? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

Exhibit 3

PERIODIC HEALTH EVALUATION

Sections 133, 1071-87, 3012, 5031 and 8012, Title 10 USC & Exec. Order 9397 (Priority Act of 1974) of PROMAN (see PEX)
USE HARD TIPPED PEN & PRESS FIRMLY, LEGIBLE COPY REQUIRED FOR DATA ENTRY

⑦ TYPE = S (Asbestos S)

RETAIN ORIGINAL IN HEALTH RECORD SEND COPY TO Commanding Officer NAVY ENVIRONMENTAL HEALTH CENTER Naval Station, Norfolk, Virginia 23511	EXAMINATION FACILITY NAME ⑥ SITE = A (North Island) UIC 	PAGE 1 of 1 CONTROL NUMBER (For NEHC Use Only)
--	---	--

① NAME (LAST) GREELEY	(FIRST) JAMES	(M.I.) C	SOCIAL SECURITY NO. 0 6 1 3 2 7 6 8 4
③ DATE OF BIRTH (DAY) 0 7 (MO) 1 4 (YR) 5 0	RACE (Check One) <input type="checkbox"/> White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian <input type="checkbox"/> Other	STATUS (Check One) <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input checked="" type="checkbox"/> Civilian	OCCUPATIONAL CODE (Civilian Employees)
② SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	YRS. GOV'T SER. 	⑧ EXAM PURPOSE CLASSIFICATION <input type="checkbox"/> INITIAL (7) <input checked="" type="checkbox"/> PERIODIC (3) <input type="checkbox"/> TERMINATION (9)	SHIPBOARD PERS. ONLY ENTER SHIP HULL NO.
④ TODAY'S DATE (DAY) 0 9 (MO) 2 6 (YR) 8 4			

RESPIRATORY QUESTIONNAIRE	RESPIRATORY PHYSICAL EXAMINATION
1. Are you currently working directly with asbestos in your job? (within the last year) CWA- <input checked="" type="checkbox"/> (YES) <input type="checkbox"/> (NO)	7. Weight (in pounds) WT 2 1 5 Height (in inches) HT 6 9
2. A. Was/is your exposure on a regular basis? (15 days per quarter or 45 days per year) RGB- <input checked="" type="checkbox"/> (YES) <input type="checkbox"/> (NO) B. How many years? (check one) Less than one <input type="checkbox"/> (A) More than one; less than five <input checked="" type="checkbox"/> (B) More than five; less than fifteen <input type="checkbox"/> (C) More than fifteen <input type="checkbox"/> (D)	8. Appearance A. Stature Normal <input type="checkbox"/> (N) Obese <input checked="" type="checkbox"/> (O) B. Chest Configuration Normal <input checked="" type="checkbox"/> (N) Increased A-P diameter <input type="checkbox"/> (I) Other chest deformity <input type="checkbox"/> (O)
C. How old were you when first exposed? AWF 2 2	C. Clubbing None <input checked="" type="checkbox"/> (N) Present <input type="checkbox"/> (P)
3. Do you usually have or have you usually had the following? (Usually means more than a quarter of the time.) A. Cough CG- <input type="checkbox"/> (YES) <input checked="" type="checkbox"/> (NO) B. Phlegm HP- <input type="checkbox"/> (YES) <input checked="" type="checkbox"/> (NO) C. Wheezing HWZ- <input type="checkbox"/> (YES) <input checked="" type="checkbox"/> (NO) D. Shortness of breath HSB- <input checked="" type="checkbox"/> (YES) <input type="checkbox"/> (NO)	9. Crackles None <input type="checkbox"/> (N) Localized late inspiratory <input type="checkbox"/> (L) Bilateral late inspiratory <input type="checkbox"/> (B) Localized early inspiratory <input checked="" type="checkbox"/> (O) Bilateral early inspiratory <input type="checkbox"/> (I)
4. Do you now or have you ever smoked cigarettes? (If no, skip to question 5.) HSCG- <input checked="" type="checkbox"/> (YES) <input type="checkbox"/> (NO) A. If so, what age did you begin? BSC 1 5 B. How much do you/did you smoke? (on average) Less than one pack per day <input type="checkbox"/> (A) One pack per day <input checked="" type="checkbox"/> (B) More than one pack per day <input type="checkbox"/> (C) More than two packs per day <input type="checkbox"/> (D) C. If you have quit, at what age did you do so? AQS 	10. Wheezes None <input checked="" type="checkbox"/> (N) Single or multiple monophonic wheezes <input type="checkbox"/> (S) Polyphonic expiratory wheezes <input type="checkbox"/> (P) Short late inspiratory, monophonic wheeze associated with inspiratory crackles <input type="checkbox"/> (H)
5. Do you smoke a pipe or cigars? (If no, skip to question 6.) A. How many years have/did you smoke a pipe or cigars? YPC SPC- <input type="checkbox"/> (YES) <input checked="" type="checkbox"/> (NO)	11. Spirometry (note decimal point) FVC: FVC observed (BTPS) in liters 3 4 2 FEV: FEV1 observed (BTPS) in liters 3 1 5
6. Have you ever had a serious lung disease requiring hospitalization? SLD- <input type="checkbox"/> (YES) <input checked="" type="checkbox"/> (NO)	

Exhibit 4

DATE OF ENCOUNTER > 9/26 (9/26/84)

Note that NOHIMS assumes
the current year.

1 DATE: 9/26/84
PROVIDERS: REED,WALTER,MD
NIGHTINGALE,FLORENCE,RN
SITE: A NORTH ISLAND
TYPE: F PERIODIC EXAM
VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM EDIT THIS
ENCOUNTER? > N NEW ENCOUNTER

When we entered 9/26/84 in response to the date prompt, NOHIMS found another encounter for that same date and displayed the header for that encounter. NOHIMS then asked if we wished to edit the existing encounter. Since we wish to enter a new encounter for 9/26/84, we entered N for No, and NOHIMS advised us that it was creating a NEW ENCOUNTER. NOHIMS will then prompt for the Header information for the new encounter.

PROVIDER 1 > REED,WALTER,MD; OCCUPATIONAL HEALTH PHYSICIAN
PROVIDER 2 >

NOHIMS first prompted for PROVIDER 1. We entered the first two letters of the last name of the provider on the *first page of the PEX Form*. You *must* enter enough letters of the provider's last name to uniquely identify him or her. NOHIMS then prompts for PROVIDER 2. If a second provider's name has been written on the PEX Form, then that provider would be entered in response to the PROVIDER 2 prompt. If there is only one name entered for the PEX PROVIDER, then simply press RETURN. However, if you enter a name at the PROVIDER 2 prompt, NOHIMS will prompt for PROVIDER 3. Ignore this prompt by pressing RETURN.

Next NOHIMS prompts for SITE, TYPE of Examination, and VISIT CLASSIFICATION as shown below.

SITE > A NORTH ISLAND
TYPE > S ASBESTOS SURVEILLANCE

VISIT CLASSIFICATION > 8 PERIODIC ASBESTOS SURVEILLANCE EXAM

PATIENT: GREELEY,JAMES C
DATE OF ENCOUNTER: 9/26/84
PROVIDER: REED,WALTER,MD
SITE: NORTH ISLAND
TYPE: ASBESTOS SURVEILLANCE

VISIT CLASSIFICATION: 8 PERIODIC ASBESTOS SURVEILLANCE EXAM

FILE,EDIT, OR IGNORE? >

>>>

We entered the information found on the 6260/5 for the SITE, TYPE, and VISIT CLASSIFICATION prompts. The SITE is found in box 6 of the overlay. The TYPE will always be S for Asbestos Surveillance. We entered the code for the VISIT CLASSIFICATION which was checked in box 8 of the overlay. When the last item of Header data has been entered, NOHIMS displays a complete list of all of the data items in the Header for your review of everything that has been entered in the encounter up to this point. Since our entries were correct, we elected to file the data by entering an F for FILE. If we had seen an error, we could have entered E to edit our responses. NOHIMS would have displayed each data item in the HEADER for us to review and/or correct.

Notice the triple caret prompt that appears after the HEADER data have been filed. This prompt signals you that NOHIMS is now looking for the entry of the Questionnaire and Physical Examination portions of the 6260/5. The triple caret prompt also reminds you that the procedures for entering data items now are somewhat different. At this point you should review the comments on Page 12 of Section 4 on the procedures for entering data items after the triple caret prompt is reached.

Let's proceed to enter the Body portion of the 6260/5 at the triple caret prompts. The Respiratory Questionnaire side of the 6260/5 should be entered first, starting with the first code, CWA, and moving down the column. The patient is to check only one of the possible responses for each of the questions. The letters in parentheses above or next to the boxes correspond to the Modifiers that must be appended to the main Code to enter the patient's responses. John Greeley has checked the Yes box for the first two questions. Therefore, we would enter CWA-Y and RGB-Y at the triple caret prompts as shown below.

```
>>> CWA-Y
      LLET6-Y CURRENTLY WORKS DIRECTLY WITH ASBESTOS (YES)
STATUS: HEALTH REVIEW
```

```
>>> RGB-Y
      LLEB7-Y ASBESTOS EXPOSURE WAS IS ON REGULAR BASIS (YES)
STATUS: HEALTH REVIEW
```

Note that when you enter the CWA-Y Code at the first triple caret prompt and press RETURN, NOHIMS displays the internal code LLET6-Y it uses to store this item, the full name of the item, and the patient's response in parentheses (YES). NOHIMS also automatically assigns a STATUS of HEALTH REVIEW to indicate that this data item is part of the patient's History. After displaying this information, NOHIMS returns with a triple caret prompt so that you can enter the next data item (RGB-Y).

John Greeley marked B to the third data item. Type Code YOE-B at the next triple caret prompt.

```
>>> YOE-B
      LLEJ8-B YEARS OF ASBESTOS EXPOSURE (MORE THAN 1 AND LESS THAN 5)
STATUS: HEALTH REVIEW
```

The next data item to be entered is Code AWF. The patient wrote age 22 in the box next to this question. This information must be entered as free text. NOHIMS will automatically prompt for free text as shown below. You enter AWF at the triple caret prompt and 22 at the 1> prompt. After typing 22 and pressing RETURN at the first line of free text, NOHIMS then prompts for a second line of text. Ignore this prompt by simply pressing RETURN. NOHIMS will return with the triple caret prompt so that you can enter the next data item. This sequence is shown below.

```
>>> AWF
      LLER9 AGE WHEN FIRST EXPOSED TO ASBESTOS
STATUS: HEALTH REVIEW
1> 22
2>
```

The patient marked No to the next three questions and Yes to the two questions after that. Correct entry for these questions is shown below.

```
>>> CG-N
      LLFL1-N COUGH HAVE OR USUALLY HAVE (NO)
STATUS: HEALTH REVIEW
```

```
>>> BP-N
      CAEF1-N...INVALID CODE
```

```
>>> HP-N
      LLFT2-N PHLEGM HAVE OR USUALLY HAVE (NO)
STATUS: HEALTH REVIEW
```

```
>>> HWZ-N
      LLFB3-N WHEEZING HAVE OR USUALLY HAVE (NO)
STATUS: HEALTH REVIEW
```

```
>>> HSB-Y
      LLFJ4-Y SHORTNESS OF BREATH HAVE OR USUALLY HAVE (YES)
STATUS: HEALTH REVIEW
```

```
>>> HSCG-Y
      LLFR5-Y HAS SMOKED CIGARETTES (YES)
STATUS: HEALTH REVIEW
```

Note that we made an entry error on the second code by typing BP-N instead of HP-N. NOHIMS displayed a message to tell us that BP-N is an invalid code and returned with the triple caret prompt so that we could enter the item again. If BP-N had been a valid code, NOHIMS would have accepted the code. Therefore, as you are entering codes you should verify that the primary name corresponds to the item you are entering. If we had entered an incorrect code, we would eliminate it by using the ERROR Status Code to flag he wrong

entry as an error and to stop it from displaying or printing in any NOHIMS reports. The ERROR Status Code is explained on Page 23 of Section 4.

So far, the patient should have marked an answer for each of the questions we have entered. However, if the patient marks No to Question 4 (Do you now or have you ever smoked cigarettes?), then he/she is to skip to Question 5. If the patient marks Yes to Question 4, then he/she is to answer Questions 4A through 4C. Therefore, you should only enter Codes BSC, PCS, and AQS if the patient answered the corresponding questions. John Greeley wrote 15 in the box next to Code BSC and checked box B for Code PCS. John Greeley left the box next to Code AQS blank; therefore, we will not enter Code AQS. The entry of these codes is shown below.

>>> BSC
LLFZ6 AGE BEGUN SMOKING CIGARETTES
STATUS: HEALTH REVIEW
1> 15
2>

>>> PCS-B
LLFG7-B AVERAGE NO OF PACKS OF CIGARETTES SMOKED (ONE PACK PER DAY)
STATUS: HEALTH REVIEW

Question 5 (Code SPC) should be completed by all patients. Question 5A (Code YPC), however, is only completed if the patient marked Yes to Question 5. Question 6 (Code SLD) should also be completed by all patients. John Greeley answered No to Question 5 so we enter SPC-N, skip Code YPC, and enter SLD-N as shown below.

>>> SPC-N
LLFX9-N SMOKES PIPE OR CIGARS (NO)
STATUS: HEALTH REVIEW

>>> SLD-N
LLGZ2-N HAD SERIOUS LUNG DISEASE REQUIRING HOSPITALIZATION (NO)
STATUS: HEALTH REVIEW

We have now finished entering the Respiratory Questionnaire side of the 6260/5. We may proceed to the right side of the form and enter the Respiratory Physical Examination data. This portion of the form is completed by the physician. He/she should mark a response for each data item.

The first two data items are Height and Weight. The amounts are entered as free text as shown next.

>>> WT
CAKH1 WEIGHT
ENTER WEIGHT > 215

>>> HT
CAJC1 HEIGHT
ENTER HEIGHT > 69

STAT, CCF, CLB, CRK, and WHZ are entered next. John Greeley's Stature is Obese, Chest Configuration is Normal, Clubbing is None, Crackles are Localized Early Inspiratory, and Wheezes are None. We would enter these codes as follows.

>>> STAT-O
LBAV3-O APPEARANCE STATURE (OBESE)
STATUS: NORMAL

>>> CCF-N
LBAC4-N APPEARANCE CHEST CONFIGURATION (NORMAL)
STATUS: NORMAL

>>> CLB-N
LBAK5-N APPEARANCE CLUBBING (NONE)
STATUS: NORMAL

>>> CRK-O
LBAS6-O CRACKLES (LOCALIZED EARLY INSPIRATORY)
STATUS: NORMAL

>>> WHZ-N
LBAA7-N WHEEZES (NONE)
STATUS: NORMAL

Note that NOHIMS displayed the internal code and full name of the item as it did for the Respiratory Questionnaire codes. The assigned STATUS however has changed to NORMAL.

The last two codes on the 6260/5 are laboratory results. In the encounter entry for the PEDS/PEX form, we entered only the codes for ordered laboratory tests. Then when the lab results were received, we entered the results using LAB RESULTS entry. In this case, we have the results at the time that we are entering the codes for the ordered tests. To enter the results at the same time as the code, we must use the following format: Code;Result. The entry of John Greeley's Spirometry test and results is shown next.

>>> FVC
WQAP4 SPIROMETRY FVC OBSERVED IN LITERS

>>> FVC;3.42
WQAP4 SPIROMETRY FVC OBSERVED IN LITERS
RESULTS: 3.42

>>> FEV;3.15
WQAE6 SPIROMETRY FEV1 OBSERVED IN LITERS
RESULTS: 3.15

>>>

In the first entry, we forgot to include the results. NOHIMS only entered the Code for the Spirometry test and did not prompt for Results. We re-entered Code FVC in the format described above. NOHIMS responded with the internal code and full name, displayed the word RESULTS, and then the number we entered. NOHIMS then gave the triple caret prompt so that we could enter the next code.

We are now done entering data for this Asbestos Surveillance encounter. When we press RETURN at the triple caret prompt, NOHIMS will ask if the encounter is complete. If you enter Y for Yes, then NOHIMS will prompt for the encounter data for another patient. If you were not done, or if you wanted to correct an error, you would enter N for No, and NOHIMS would respond with the triple caret prompt again. We are satisfied that we have entered all of the data items on the 6260/5 correctly, so we elect to go on by entering Y at the ENCOUNTER COMPLETE? prompt.

>>>
ENCOUNTER COMPLETE? Y
ENTER ENCOUNTER FOR PATIENT >

We may now enter another encounter for the same patient, enter an encounter for a different patient, or return to the ENTER MEDICAL DATA OPTION prompt by pressing RETURN.

LAB RESULTS ENTRY

Lab tests and other diagnostic procedures are scheduled or ordered by the physician, nurse, or occupational technician during a patient's visit and the information is recorded on the Physical Exam Data Sheet (PEDS) Encounter Form previously described. Therefore, initial information about a lab test is intended to be entered into the patient's record in the ENCOUNTER option.

In the ENCOUNTER option, lab tests can be entered with one of two different statuses: Ordered or completed with Results to be entered. The Default status is Ordered, which implies that the test has been scheduled and only the code for the test is entered. By entering an asterisk following the lab test code, both a completed test and its results can be entered in the ENCOUNTER option.

Since lab results most often become available after the encounter data have been entered, NOHIMS was designed to provide for direct entry of lab result data without going through the entry or verification of the administrative or Header data in the ENCOUNTER and MEDICAL EDIT options. Consequently, the usual data entry sequence for lab tests is to record the ordered test using the ENCOUNTER option and then to record the test results using the LAB RESULTS option. A firm rule to be followed is that all lab results are entered for the date they were ordered. Unless this rule is followed, some lab results will be entered as separate encounters, leaving the lab tests they pertain to showing as ordered but not resulted in the originating encounter.

The procedures for entering test results using the LAB RESULTS option are similar to those used for entering and editing encounter data. The major difference in the LAB RESULTS option is that the code or name being entered does not require the asterisk (*) at the end to indicate structured data entry. This difference is because the intent of the LAB RESULTS option is to record lab results which are structured data; so the asterisk (*) can be omitted. However, if a free text comment is to be entered with lab results, then the asterisk is required in order to tell NOHIMS that free text will be entered. Also, in the LAB RESULTS option medical data entries can only be changed. They cannot be deleted with an Error status; this must be done in the ENCOUNTER or MEDICAL EDIT options.

Results for tests ordered at different encounters may be entered at one time for a patient. There is no need to presort lab reports by the encounter date. However, they should be grouped by patient to minimize the number of times the patient's record is called up.

Lab results can be of three types: (1) single result tests such as Hemo- globin, Radiology, Heavy Metal Tests, and Electrocardiogram; (2) listcode panels such as Complete Blood Count, Differential with Morphology, Audiometry, and SMAC panel; or (3) multiple result tests such as Differential Count, Urinalysis, and Pulmonary Function Test. The single result tests are the basic unit of lab results entry. One result and/or comment is entered per NOHIMS code.

If a test is a listcode panel, a series of single result tests are triggered when you enter the NOHIMS listcode. An example of this is the Complete Blood Count (CBC). You enter one result for each single result test as NOHIMS prompts for them. The number of single result tests depends on the listcode panel. For example, listcode panel CBC prompts for five single result tests, while the SMAC listcode panel has 21 prompts for single result tests.

The multiple result tests are entered using special NOHIMS programs. When you enter the multiple result test code, such as UA for Urinalysis, the special program is triggered. You then enter a number of results as NOHIMS prompts for them. The difference between a multiple result test and a listcode panel will become clear as we go through some examples of lab results entry.

To illustrate the LAB RESULTS option, the following data will be entered for our example patient, Chester Cowrey. Notice that the list has results for tests ordered on different dates and has several results for each of the types of tests mentioned above.

List of Lab Results for Chester Cowrey

<u>Code</u>	<u>Test Name</u>	<u>Date Ordered</u>	<u>Name of Provider</u>	<u>Exhibit</u>
HB	Hemoglobin	10/12/84	Salk,J	5
CPL	Chest Xray PA and Lateral	9/25/84	Reed,W	6
EKG	Electrocardiogram	9/25/84	Reed,W	7
CSB	Chest Xray Asbestos	10/12/84	Salk,J	8
HMSC	Heavy Metal Test for Serum Copper	10/12/84	Salk,J	9
CMQ	Quantitative Carbon Monoxide	8/2/84	Reed,W	10
CBC	Complete Blood Count	9/25/84	Reed,W	11
SMCB	SMAC for Liver Kidney and or Blood Chemistry	9/25/84	Reed,W	12
AOT	Audiogram for Other Administrative Reason	9/25/84	Reed,W	13,14
ENX	Audiogram for Excessive Noise Exposure	10/12/84	Salk,J	15,16
DFF	Differential with Morphology	9/25/84	Reed,W	11

UA	Urinalysis	9/25/84	Reed,W	17
PFTA	Pulmonary Fxn Test Asbestos	10/12/84	Salk,J	18

At the ENTER MEDICAL DATA OPTION prompt, select the LAB RESULTS option and enter the patient's name or social security number. You may use the shortcut method of identifying a patient.

ENTER MEDICAL DATA OPTION > LAB RESULTS
ENTER LAB RESULTS FOR PATIENT > CO,C;M;

1 COWREY,CHESTER M 3/28/33 558-63-4920 P

Is this the patient? <Y>

>>>

NOHIMS found Chester Cowrey in response to our entry of CO,C;M; at the ENTER LAB RESULTS FOR PATIENT prompt. When we pressed RETURN to accept Y (for Yes) at the Is this the patient prompt, NOHIMS responded with a triple caret prompt (>>>). The LAB RESULTS option is used only for entering items in the Laboratory Tests Division. If other changes need to be made to the Encounter record, they are made using the MEDICAL EDIT option described in the next subsection.

SINGLE RESULT TESTS

The first lab results we will enter are examples of single result test entry. Entry for the first test on the list of lab results for Chester Cowrey, Hemoglobin, is shown below. Because the purpose of this option is to enter lab results, which are structured data, you do not need to enter an asterisk to indicate that results will follow as is done in the ENCOUNTER and MEDICAL EDIT options. If free text/comment is to be entered in addition to results, the asterisk is required. Chester Cowrey's Hemoglobin Test result is shown in Exhibit 5.

>>> HB
MNBY1 HEMOGLOBIN

10/12/84 PROVIDER: SALK,JONAS,MD
MNBY1 HEMOGLOBIN

OK Y
RESULTS > 14 <NORMAL>

>>>

<p>COWREY, CHESTER 558-63-4920 WL-10 3/28/33 NASNI</p>		<p style="text-align: right;">SPECIMEN/LAB RPT NO</p> <p>HEMATOLOGY</p> <p>URGENCY</p> <p><input type="checkbox"/> ROUTINE</p> <p><input type="checkbox"/> TODAY</p> <p><input type="checkbox"/> PRE-OP</p> <p>STAT <input type="checkbox"/></p> <p>PATIENT STATUS</p> <p><input type="checkbox"/> BED</p> <p><input type="checkbox"/> OUTPATIENT</p> <p><input type="checkbox"/> NP</p> <p><input type="checkbox"/> AMB</p> <p><input type="checkbox"/> DOM</p> <p>SPECIMEN SOURCE</p> <p><input type="checkbox"/> VEIN</p> <p><input type="checkbox"/> CAP</p> <p><input type="checkbox"/> OTHER (Specify)</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">LABORATORY FILE</p>	
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE			
<p>REQUESTING PHYSICIAN'S SIGNATURE</p> <p><i>Salk, Jonas/ms</i></p>		<p>REPORTED BY</p> <p><i>KH</i></p> <p>MD/DATE</p> <p><i>10/12/84</i></p> <p>TECH</p>	
<p>REMARKS</p> <p><i>Hemoglobin APE</i></p>		<p>LAB. NO. NO</p>	

SPECIMEN TAKEN		HEMATOLOGY										S4B-108																			
DATE	TIME	TEST	REQUESTED	WBC COUNT	HEMOGLOBIN	HEMATOCENT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEG	LYMPHS	EOSINOPHILS	MONOCYTES	PLATELETS	RBC	SED RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	P. CONTROL	P. PATIENT	C. CONTROL	C. PATIENT	% ACTIVITY	FAIR	SKENING TEST	LE PREP

Exhibit 5

HEMOGLOBIN LAB CHIT

After the code was entered, NOHIMS responded with the internal code and the name of the test. Then, an encounter date and the care provider name was displayed. When a lab test name or code is entered in response to the >>> prompt, NOHIMS searches the patient's record for all entries of the code with a status of Pending or Ordered. The date of the latest entry is displayed. The OK prompt is asking you to verify the name of the provider and date of the encounter at which the test was ordered. When Y for Yes is entered, NOHIMS then asks for the results. When the results are entered and RETURN is pressed, NOHIMS indicates that they are within the normal range. Press RETURN again to accept the normal status.

Notice that in the previous example, the wrong result was entered---14 instead of 12. The test code can be entered again to make a correction.

```
>>> HB
      MNBY1 HEMOGLOBIN
```

```
DATE > 10/12 (10/12/84)
```

```
1. DATE: 10/12/84
   PROVIDER: SALK,JONAS,MD
   SITE: A NORTH ISLAND
   TYPE: F PERIODIC EXAM
   VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM
OK? Y
MNBY1 HEMOGLOBIN
```

```
14
STATUS: NORMAL
RESULTS > 12 <ABNORMAL>
```

```
>>>
```

After the code was entered the second time, NOHIMS searched the patient's record for another entry of the code in an Ordered or Pending status. Remember, NOHIMS only selects tests with a status of Pending or Ordered. Because the results from the first entry were recorded in the patient's file, NOHIMS did not select that date again. There were no other entries for this code; so NOHIMS asked for an encounter date to be entered. After the date was entered, NOHIMS found the record for the encounter and displayed a summary of the Header information for verification. After we responded Y for Yes to the OK? prompt, NOHIMS then displayed the results that were recorded for the test and a prompt for new results to be entered. The correct result then was entered, and NOHIMS indicated that the results were ABNORMAL. Similar to the ENCOUNTER and MEDICAL EDIT options, the second entry of the code for this test replaced the first. Remember, however, that only changes or additions can be made in the LAB RESULTS option. Entered items cannot be deleted with an Error status, as can be done in the ENCOUNTER and MEDICAL EDIT options.

The second lab result to be entered is for a Chest Xray PA and Lateral. The list of lab results tells us that the code for a Chest Xray PA and Lateral

is CPL. When you are doing live entry of Radiology chits, you will have to look up the code of the Xray on the NOHIMS job aid of Radiology codes. This job aid contains a list of all Radiology codes in NOHIMS with their corresponding Xray names. The Radiology chits for the CPL and CSB codes will look similar. Sometimes on a CSB Radiology chit the HISTORY field at the end of the header will say ASBESTOS PHYSICAL. If you are unsure which code is correct, you should enter CPL as it is more common. If NOHIMS responds with the DATE prompt, it means NOHIMS did not find a CPL code with a status of Ordered. You would then press RETURN at the DATE prompt, and at the >>> prompt you would enter CSB to see if a Chest Xray Asbestos was ordered.

It should be noted that sometimes the date on the Radiology chit is one working day later than the date in NOHIMS because of the time involved in transferring the Xrays to Balboa Naval Hospital for reading. The results should be recorded for the date stored in NOHIMS, the day the Xray was ordered.

Enter CPL to enter the results for the Chest Xray PA and Lateral. Exhibit 6 contains Chester Cowrey's CPL results.

>>> CPL
SNAT3 CHEST XRAY PA AND LATERAL

10/15/84 PROVIDER: WELBY, MARCUS, MD
SNAT3 CHEST XRAY PA AND LATERAL

OK? N

9/25/84 PROVIDER: REED, WALTER, MD
SNAT3 CHEST XRAY PA AND LATERAL

OK? Y
SNAT3 CHEST XRAY PA AND LATERAL

RESULTS > ?

ENTER "POSITIVE FINDING", "QUESTIONABLE", "NL"
OR "NO ACTIVE DIS" AS INDICATED ON THE RADIOLOGY CHIT.
RESULTS > NO ACTIVE DIS <NORMAL>

>>>

The first visit date displayed by NOHIMS did not correspond to the one on the lab results list or on the Radiology chit, so we responded N for No to the OK? prompt, and NOHIMS responded with the next latest date on which the test was ordered. This date was correct, so we responded Y for Yes. At the RESULTS prompt, we entered (?) to be certain of how the radiology results were to be entered. NOHIMS responded with a comment that told us the choices. We entered NO ACTIVE DIS because these words were underlined in the Radiologist's impression. The impression will say Normal if NL (Normal Limits) is to be entered. NOHIMS then displayed a status of NORMAL. We pressed RETURN to accept the Normal status.

DEPARTMENT OF RADIOLOGY
NAVAL HOSPITAL
San Diego, California 92134

ID NO: 70-558-63-4920

Cowrey, Chester	51 M	ID No: 70-558-63-4920
DOB: 3/28/33	WD/CL:	Status: ON
Case #: 083630	Type: omo	Med. Rec. Loc: NARF 6654
Arrived: 1:28pm 9/26/84		DR: Reed, Walter
History: ANNUAL PHYSICAL EXAM		

PA CHEST:

There is mild scalloping of both hemidiaphragms, which should be of no clinical significance. I see no evidence of active disease.

kl

s/ CDR A. Livingston, MC USNR

REPORT OF RADIOLOGIC CONSULTATION

ORIGINAL

Exhibit 6

RADIOLOGY LAB CHIT

(Chest Xray PA and Lateral)

The next item on the list of lab results to be entered for Chester Cowrey is an Electrocardiogram. Exhibit 7 shows that a comment is to be entered with the result; be certain to enter an asterisk after this code so that NOHIMS will prompt for a free text entry/comment.

>>> EKG*
WPAN1 ELECTROCARDIOGRAM

9/25/84 PROVIDER: REED,WALTER,MD
WPAN1 ELECTROCARDIOGRAM

OK? Y
WPAN1 ELECTROCARDIOGRAM

RESULTS > ABNORMAL <ABNORMAL>
1> ST DEPRESSION
2>

>>>

We entered ABNORMAL at the RESULTS prompt because that box was checked under RESULTS on the EKG form. We then accepted the Abnormal status NOHIMS displayed. The comments on the EKG form were entered at the 1> prompt. We pressed RETURN at the 2> prompt to return to the triple caret prompt.

The next item, Exhibit 8, should be routine for you by now. For practice, enter the long name for the test.

>>> CHEST XRAY ASBESTOS*
SNAD1 CHEST XRAY ASBESTOS

10/12/84 PROVIDER: SALK,JONAS,MD
SNAD1 CHEST XRAY ASBESTOS

OK? Y
SNAD1 CHEST XRAY ASBESTOS

RESULTS > QUESTIONABLE <ABNORMAL>
1> SHADOW ON LEFT LOBE. ORDER REPEAT XRAY.
2>

>>>

We entered an asterisk (*) after the test name because we saw from the chit that a comment would be entered. We knew to enter QUESTIONABLE at the RESULTS prompt because the physician wrote a Q on the Radiology chit in Exhibit 8. The physician will mark a P on the chit if the result is POSITIVE FINDING. At the 1> prompt, we entered both the words the physician underlined and wrote on the chit.

OCCUPATIONAL HEALTH CARE
EKG RESULTS

E K G

PATIENT NAME		
<u>C O W R E Y</u>		<u>C H E S T E R</u>
LAST NAME	FIRST NAME	M.I.
SEX	DATE OF BIRTH	DATE OF EKG
<input checked="" type="checkbox"/> (M) Male <input type="checkbox"/> (F) Female	<u>03</u> / <u>28</u> / <u>33</u>	<u>09</u> / <u>25</u> / <u>84</u>
	MONTH DAY YEAR	MONTH DAY YEAR

EKG Check only one.
(EKG)

RESULTS:

- ☐ Normal
☐ Questionable
☒ Abnormal

COMMENTS:

If not normal, state Impression (for example,
sinus bradycardia, ST depression, etc.):

(*) ST depression

NHRC [08-24-84]

Exhibit 7
EKG LAB CHIT

DEPARTMENT OF RADIOLOGY
NAVAL HOSPITAL
San Diego, California 92134

ID NO: 70-558-63-4920

Cowrey, Chester	51 M	ID No: 70-558-63-4920
DOB: 3/28/33	WD/CL:	Status: ON
Case #: 084532	Type: omo	Med. Rec. Loc: NARF 6654
Arrived: 2:14pm 10/13/84		DR: Salk, Jonas
History: ASBESTOS PHYSICAL		

PA CHEST:

A single PA view of the chest reveals a shadow on the left lobe.
Recommend comparison to previous PAs or repeat of radiograph.

kl

s/ CDR A. Livingston, MC USNR

REPORT OF RADIOLOGIC CONSULTATION

ORIGINAL

Exhibit 8

RADIOLOGY LAB CHIT

(Chest Xray for Asbestos)

The next test on the list for Chester Cowrey, Heavy Metal Serum Copper, was not marked on the PEDS form for that date. Consequently, it was not entered into the NOHIMS record. If there are no other entries of an ordered Heavy Metal Serum Copper test in the patient's record, when you enter the code for the test NOHIMS will ask you to enter the date of the test as shown below.

>>> HMSC
LPAB2 HEAVY METAL SERUM COPPER

DATE > 10/12 (10/12/84)

1. DATE: 10/12/84
PROVIDER: SALK, JONAS, MD
SITE: A NORTH ISLAND
TYPE: F PERIODIC EXAM
VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM
OK? Y
RESULTS > 1.53 <NORMAL>

>>>

When the date was entered, NOHIMS found the record of the encounter for that date, displayed a summary of the Header information, and asked if this is the correct encounter. We responded Y for Yes. Then NOHIMS asked for the results. Exhibit 9 shows that the result was 1.53. We accepted the NORMAL status.

Ideally, you should not have to do this procedure very often. If you must frequently enter the date for the lab result as we just did, you should notify your System Manager so that the problem can be investigated.

The next test on the lab results list for Chester Cowrey, Quantitative Carbon Monoxide in Exhibit 10, has a date for which no encounter has been recorded. Also, the test has not been recorded at any other encounter.

>>> CMQ
HQCE8 QUANTITATIVE CARBON MONOXIDE

DATE > 8/2/84

PROVIDER >

Because there is no encounter for 8/2/84, NOHIMS prompted for the basic encounter header information. The PROVIDER prompt serves as a warning to you that an encounter for that date has not yet been entered into NOHIMS. A data entry backlog can happen from time to time if the patient load in the clinic is particularly heavy. The appearance of the PROVIDER prompt is a warning flag to you to refrain from entering the result(s). Set that lab report aside and try again later. Eventually, the encounter will be entered and the

COWREY, CHESTER
558-63-4920
WL-10
3/28/33

NASNI

SPECIMEN/LAB RPT NO		PATIENT'S MED. RECORD
MISC		
URGENCY <input checked="" type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> PRE-OP <input type="checkbox"/> STAT	PATIENT STATUS <input type="checkbox"/> BED <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> NP <input type="checkbox"/> AMB <input type="checkbox"/> DOM	
SPECIMEN SOURCE (Specify)		
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE		
REQUESTING PHYSICIAN'S SIGNATURE	REPORTED BY	MD DATE
Salk, Jonas/kl	KGL	10/12/84
LAB ID NO		
REMARKS		
Serum Copper ENVIRONMENTAL HEALTH SERVICE NRMAC BLDG 1-B 233-2442 THE RESULT OF THE ANALYSIS FOR S Cu — IS — 1.53 mg/dL COMPARATIVE VALUES ARE: NORMAL (UNEXPOSED) — 1-2 mg/dL ACCEPTABLE (EXPOSED) — EXCESSIVE (ILL HEALTH EFFECTS) —		
TESTS	SPECIMEN TAKEN	DATE
	TIME	
	REQUESTED	
	RESULTS	

557-031
MISCELLANEOUS
STANDARD FORM 157 (Rev. 3-77)
General Services Administration and GPO
GPO: 1977 O-274-111-1

Exhibit 9

HEAVY METAL LAB CHIT

NAME <u>COWREY, CHESTER</u> SOC.SEC.# <u>558-63-4920</u> RANK/RATE <u>WL-10</u> STATE OF BIRTH _____ DATE OF BIRTH <u>3/26/33</u> DUTY STATION _____ NASN: _____		MISC URGENCY <input type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> PRF OP <input type="checkbox"/> STAT		SPECIMEN/LAB RPT NO <u>FBA</u> PATIENT STATUS <input type="checkbox"/> RFD <input type="checkbox"/> AMR <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> <input type="checkbox"/> NP <input type="checkbox"/> DIM SPECIMEN SOURCE (Specify) <u>Blood</u> LAB ID NO. _____		PATIENTS MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO—DATE						
REQUESTING PHYSICIAN'S SIGNATURE <u>Reed, Walter/k2</u>		REPORTED BY <u>JK TECH</u>		MD DATE <u>8/2/84</u>		
REMARKS <u>Quan CO</u>						
TEST(S)	SPECIMEN TAKEN	TIME	REQUESTED	RESULTS	2%	
DATE	DATE	TIME				
8/2/84	8/2/84	1:30				

MISCELLANEOUS 557-108
 Standard Form 108-1
 Group Service Administration, Inc.
 10000 1st Avenue, S.W.
 Seattle, WA 98148

Exhibit 10
 LAB CHIT FOR QUANTITATIVE CARBON MONOXIDE

PROVIDER prompt will disappear---your cue that it is all right to proceed with entering the result(s). If after several tries there is still no encounter for that date, notify the System Manager so that the problem can be investigated.

To get back to the triple caret prompt, we must enter an ^Q at the PROVIDER prompt. NOHIMS will display the END OF LAB INPUT FOR THIS PATIENT? prompt. If you did not have any more laboratory results for this patient, you would enter Y for Yes. We have several more lab results to enter for Chester Cowrey, so we will enter N for No.

```
PROVIDER > ^Q
END OF LAB INPUT FOR THIS PATIENT? N
```

>>>

LISTCODE PANELS

The next five tests on the list for Chester Cowrey are listcode panels. When the name or code for one of these tests is entered in PEDS/PEX encounter entry, NOHIMS is told that a series of tests have been ordered. If a provider wanted to order only one or two of the tests within the series, the individual test name or code would have been recorded instead. Accordingly, when the name of the panel of tests is entered, NOHIMS assumes that every test will be performed and that eventually the results for each test will be entered.

After the code or name for the test panel is entered, the results for each individual test are entered sequentially. To illustrate the entry of a listcode panel, we will enter the next lab test to be resulted on our list, the Complete Blood Count. Enter the code or name of the test at the triple caret prompt.

```
>>> CBC
      MNAA2  COMPLETE BLOOD COUNT
```

```
9/25/84          PROVIDER: REED,WALTER,MD
MNAA2  COMPLETE BLOOD COUNT
```

```
OK? Y
```

```
MNBD5  RED BLOOD CELL COUNT
RESULTS >
```

The encounter date indicated by NOHIMS is correct, so we respond Y for Yes. Next, NOHIMS displays the code and name for the first test of this series and asks for results to be entered. Entry of the laboratory results from the chit shown in Exhibit 11 would look like the following.

NAME <u>COWREY CHESTER</u> SOC SEC. # <u>558-63-4920</u> RANK/RATE <u>WL-10</u> STATE OF <u>IL</u> DATE OF BIRTH <u>3/28/33</u> DUTY STATION <u>X-RAY NASNI</u>		SPECIMEN/LAB RPT NO. HEMATOLOGY URGENCY <input checked="" type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> PRE-OP STAT <input type="checkbox"/> PATIENT STATUS <input type="checkbox"/> BED <input type="checkbox"/> AMB <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> UOAM <input type="checkbox"/> NP SPECIMEN SOURCE <input checked="" type="checkbox"/> VEIN <input type="checkbox"/> CAP <input type="checkbox"/> OTHER (Specify)	
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE REQUESTING PHYSICIAN'S SIGNATURE <u>Reed, Walter/kl</u>		REPORTED BY <u>KM</u> MD DATE <u>9/25/84</u> LAB ID NO.	
REMARKS <u>CBC & Diff</u>			

TESTS	SPECIMEN TAKEN	DATE	TIME	A.M. P.M.	REQUESTED	(H)	RESULTS										WBC DIFF AND BLOOD CELL MORPH	RBC	HGB	HCT	PLATELET COUNT	PLATELET	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	P	T	CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
							WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	SED RATE																			
					5.62		WBC COUNT																												
					16.6		HEMOGLOBIN																												
					48.8		HEMATOCRIT																												
					87		MCV																												
							MCH																												
							MCHC																												
					7.70		WBC COUNT																												
					12		IMMATURE																												
							NEUTRO-BANDS																												
							NEUTROSEGS																												
							LYMPHS																												
							EOSINOPHILS																												
							BASOPHILS																												
							MONOCYTES																												
							PLATELETS																												
							SED RATE																												
							PLATELET COUNT																												
							RETICULOCYTE COUNT																												
							CLOTTING TIME																												
							BLEEDING TIME																												
							P																												
							T																												
							CONTROL																												
							PATIENT																												
							CONTROL																												
							PATIENT																												
							% ACTIVITY																												
							RATIO																												
							SICKLING TEST																												
							LE PREP																												

Exhibit 11

LAB CHIT FOR COMPLETE BLOOD COUNT
WITH DIFFERENTIAL

MNBD5 RED BLOOD CELL COUNT
RESULTS >

ENTER A NUMBER IN THE FORMAT OF N.NN
RESULTS ARE IN MILLIONS PER CUBIC MILLIMETER
RESULTS > 5.62 <NORMAL>

At the RESULTS prompt, we entered a question mark (?) to find out how the data should be entered. There is a question mark response for every laboratory test should you need to be reminded of the required format of the data. We entered 5.62 and pressed RETURN. NOHIMS compared the value we entered to the normal values for that code and displayed the status in brackets. Press RETURN again to accept the status NOHIMS assigned. The results for most members of a listcode panel will be checked against a range of normal values, but it is not unusual if some results do not receive a status.

MNBY1 HEMOGLOBIN
RESULTS > 16.6 <NORMAL>

MNBN3 HEMATOCRIT
RESULTS > 48.3 <NORMAL>

MNRW4 MEAN CORPUSCULAR VOLUME
RESULTS > 87 <NORMAL>

MNDJ1 WHITE BLOOD CELL COUNT
RESULTS > 7700 ???

RESULTS > ?

ENTER THE NUMBER ON THE LAB CHIT IN THE FORMAT
OF N.N. IF THE RESULTS ARE LISTED AS N,NNN
ENTER AS N.N. FOR EXAMPLE, 7,800 SHOULD BE
ENTERED AS 7.8. RESULTS ARE IN NUMBER PER CUBIC
MILLIMETER.
RESULTS > 7.7 <NORMAL>

>>>

At the WHITE BLOOD CELL COUNT RESULTS prompt, we entered a value which was not in the acceptable range of values for this code. NOHIMS responded with three question marks to tell us to re-enter the data. We entered a question mark for help at the the next RESULTS prompt to find out how to enter the data on the laboratory chit. At the RESULTS prompt that NOHIMS displayed after the help text, we re-entered the RESULT for the White Blood Cell Count in the correct format. White Blood Cell Count is the last member code in the CBC listcode panel, so after we entered the RESULT, NOHIMS responded with the triple caret prompt to indicate that we may enter a result for another lab test.

If an error is made while entering the result of a test in a listcode panel such as the CBC, the correction is made with the internal code or name of the individual test rather than with the panel name. The job aids which come with this manual contain the internal codes and names of the component tests of the SMCB, CBC, and Differential with Morphology panels. The codes for the Audiology listcode panels are on the overlays which are discussed later in this section.

Notice that a mistake was made for the third test on the list---
HEMATOCRIT; a result of 48.3 was entered instead of 48.8. Enter the panel name again and the date of the encounter. Notice the message from NOHIMS.

>>> CBC
MNA22 COMPLETE BLOOD COUNT

A date is
requested because
the code for the CBC
is no longer in in
Ordered or Pending
status.

DATE > 9/25/84

1. DATE: 9/25/84
PROVIDER: REED,WALTER,MD
SITE: A NORTH ISLAND
TYPE: F PERIODIC EXAM
VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM

OK? Y
MNA22 COMPLETE BLOOD COUNT

STATUS: NORMAL
RESULTS MAY ONLY BE CHANGED AT ENTRY OF INDIVIDUAL CODES

>>>

Look up the internal code for Hematocrit on the job aid. Enter the code for the individual test and encounter date. Now we can proceed to enter the correct result, which will in turn put the correct entry into the patient's record.

>>> MNB3 HEMATOCRIT

DATE > 9/25/84

1. DATE: 9/25/84
PROVIDER: REED,WALTER,MD
SITE: A NORTH ISLAND
TYPE: F PERIODIC EXAM
VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM

OK? Y
MNB3 HEMATOCRIT

48.3
STATUS: NORMAL
RESULTS > 48.8
<NORMAL>

>>>

The next lab result on the list is the SMAC panel. To illustrate how NOHIMS responds to a partial entry of results for a listcode panel, we will enter the results in two parts. First, enter the code for the SMAC panel, SMCB.

>>> SMCB
WRFV4 SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY

9/25/84 PROVIDER: REED,WALTER,MD
WRFV4 SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY

OK? Y

CNEC2 GLUCOSE SERUM FASTING Glucose
RESULTS >

The encounter date indicated by NOHIMS is correct; so we respond Y for Yes. NOHIMS displayed the internal code and name of the first test of this panel and then asked for results to be entered. The first prompt is for Glucose Serum Fasting. Enter the result as it appears on the lab chit, then proceed through the results for CALCIUM Ca as follows, entering the results found in the SMAC panel shown in Exhibit 12. Note that on the SMAC panel chit, abbreviations such as "NA" and "K" are used to identify each result. When NOHIMS displays the name of each test in the panel, it is followed by the abbreviation used on the lab chit. Also, NOHIMS prompts for the tests in the same order as they appear on the lab chit.

CNEC2 GLUCOSE SERUM FASTING Glucose
RESULTS > 87 <NORMAL>

CNBD1 SODIUM Na
RESULTS > 145 <NORMAL>
CNBL2 POTASSIUM K
RESULTS > 4.1 <NORMAL>
CNBT3 CHLORIDES SERUM Cl
RESULTS > 105 <NORMAL>

CNCG8 CARBON DIOXIDE SERUM CO2
RESULTS > 22 <ABNORMAL>

CNCP5 CREATININE BLOOD Cr
RESULTS > 1.3 <NORMAL>

CNCZ3 BLOOD UREA NITROGEN Bun
RESULTS > 8 <NORMAL>

CNPT1 URIC ACID BLOOD Ua
RESULTS > 5.4 <NORMAL>

RUN: SEP 28, 1984
2:31 AM
1984

NAVAL HOSPITAL, SAN DIEGO, CA
OUTPATIENT REPORT BY REQUESTING LOCATION FOR: SEP 27,

PAGE 1

***** F O R O F F I C I A L U S E O N L Y *****
DATA CONTAINED HEREIN ARE SUBJECT TO THE PRIVACY ACT OF 1974

PATIENT NAME	PATIENT ID	LOCATION	SEX	AGE	TELEPHONE
COWREY, CHESTER	70-558-63-4920	NH	M	51	

0910:PC0138R RESULTED REQ HCP: DR. NAME NOT IN SYSTEM NIS REQ LOC: NI

COLLECTED: 09/25/84 10:33 AM RECEIVED: 09/26/84 3:58 AM

COMMENT: 20895

ORDERED: CHEMISTRY PANEL

GLUCOSE	87	MG/DL	(70-105)
NA	145	MEQ/L	(136-145)
K	4.1	MEQ/L	(3.5-5.3)
CL	105	MEQ/L	(97-109)
CO2	22*	MEQ/L	(24-30)
CR	1.3	MG/DL	(0.4-1.5)
BUN	8	MG/DL	(7-26)
UA	5.4	MG/DL	(3.9-9.0)
CA	8.7	MG/DL	(8.5-10.5)
P	3.8	MG/DL	(2.5-4.9)
TB	0.3	MG/DL	(0.2-1.2)
DB	0	MG/DL	(0-0.5)
TP	6.2	G/DL	(6.0-8.5)
ALB	3.6	G/DL	(3.0-5.5)
ALP	113	IU/L	(30-115)
ALT (SGPT)	24	IU/L	(0-45)
SGOT (AST)	29	IU/L	(0-41)
LD	122	IU/L	(60-200)
CK	QNS	IU/L	(0-225)
CHOL	132*	MG/DL	(150-310)
TRIG	344*	MG/DL	(40-160)

Exhibit 12

SMAC PANEL LAB CHIT

CNFA1 CALCIUM Ca
RESULTS > 8.7 <NORMAL>

Now, let's assume that we have been called away from our data entry task for awhile. Enter ^Q in response to the RESULTS prompt. Then complete the lab test entry for our example patient, Chester Cowrey, by responding Y for Yes to the END OF LAB INPUT FOR THIS PATIENT? prompt.

CNAF2 INORGANIC PHOSPHATE P
RESULTS > ^Q
END OF LAB INPUT FOR THIS PATIENT? Y
ENTER LAB RESULTS FOR PATIENT >

The results for the first nine tests of the SMAC listcode panel plus all other lab results entered now will be recorded in the patient's record. To complete the entry of the results of the SMAC panel, enter the patient's identifying information.

ENTER LAB RESULTS FOR PATIENT > CO,C;M;

1 COWREY,CHESTER M 3/28/33 558-63-4920 P

Is this the patient? <Y>

>>>

Now enter the code for the SMAC panel again.

>>> SMCB
WRFV4 SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY

9/25/84 PROVIDER: REED,WALTER,MD
WRFV4 SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY
THE FOLLOWING HAVE NOT BEEN RESULTED:
CNAF2 INORGANIC PHOSPHATE P
CNKX1 BILIRUBIN TOTAL Tb
CNKE2 BILIRUBIN DIRECT Db
EPBL1 TOTAL SERUM PROTEINS Tp
EPCR1 ALBUMIN Alb
ENPF2 FRACTIONATED ALKALINE PHOSPHATASE Alp
ENBN5 SERUM GLUTAMIC PYRUVIC TRANSAMINASE Alt
ENBH1 SERUM GLUTAMIC OXALOACETIC TRANSAMINASE Sgot
ENGA3 LDH ISOENZYMES Ld
ENHF3 CREATINE PHOSPHOKINASE ISOENZYMES Ck

(Continued)

CPCM1 CHOLESTEROL BLOOD Chol
CPCS5 TRIGLYCERIDES Trig

OK? Y

CNAF2 INORGANIC PHOSPHATE P
RESULTS >

Notice the message from NOHIMS. We are told the internal codes and names of the remaining tests for which a result was not entered and then asked if this is the panel for which we wish to complete entering results. We respond Y for Yes and proceed through to the end.

CNAF2 INORGANIC PHOSPHATE P
RESULTS > 3.8 <NORMAL>

CNKX1 BILIRUBIN TOTAL Tb
RESULTS > 0.3 <NORMAL>

CNKE2 BILIRUBIN DIRECT Db
RESULTS > 0 <NORMAL>

EPBL1 TOTAL SERUM PROTEINS Tp
RESULTS > 6.2 <NORMAL>

EPCR1 ALBUMIN Alb
RESULTS > 3.6 <NORMAL>

ENPF2 FRACTIONATED ALKALINE PHOSPHATASE Alp
RESULTS > 113 <NORMAL>

ENBN5 SERUM GLUTAMIC PYRUVIC TRANSAMINASE Alt
RESULTS > 24 <NORMAL>

ENBH1 SERUM GLUTAMIC OXALOACETIC TRANSAMINASE Sgot
RESULTS > 29 <NORMAL>

ENGA3 LDH ISOENZYMES Ld
RESULTS > 122 <NORMAL>

ENHF3 CREATINE PHOSPHOKINASE ISOENZYMES Ck
RESULTS > QNS
NUMERIC INPUT PLEASE
RESULTS > ...NO ACTION

CPCM1 CHOLESTEROL BLOOD Chol
RESULTS > 132 <ABNORMAL>

CPCS5 TRIGLYCERIDES Trig
RESULTS > 344 <ABNORMAL>

>>>

The result on the laboratory chit for CREATINE PHOSPHOKINASE ISOENZYMES Ck was QNS (Quantity Not Sufficient), but NOHIMS requires numeric input. We simply pressed RETURN at the next RESULTS prompt and NOHIMS responded with a NO ACTION message to indicate that results would not be filed for that test.

You should also null through the RESULTS prompt when the laboratory chit for the SMAC panel shows that a test(s) result is still pending. If the SMAC panel has a test(s) which is pending, you will receive another copy of the SMAC chit with the complete panel results when the pending test(s) is completed. At that time, when you enter SMCB at the triple caret prompt to enter the results on the new complete chit, NOHIMS will list the tests which have not yet been resultated. When you press RETURN at the OK? prompt, NOHIMS will allow you to enter results for just those tests that need results.

You can see that entering the results for a listcode panel actually is easier than entering each test in the series individually. All you need to do is to enter the code or name for the panel once, and then NOHIMS will respond with the names of the individual tests and prompt for results.

Another example of a listcode panel is audiometry results. An audiogram may be given for one of three reasons: Audiogram for Excessive Noise Exposure, Audiogram for Other Administrative Reason, or Audiogram for Employee Complaint Only. The results for the audiograms are recorded on one of two forms, the Reference Audiogram form (DD 2215) or the Hearing Conservation Data form (DD 2216). The DD 2215 is used for reference audiograms; subsequent audiograms are recorded on the Hearing Conservation Data form. There is no correlation between the reason for the audiogram and the form that is used; either form may be used to record the results of the audiogram regardless of the reason for the test.

The first audiogram that Chester Cowrey received was an Audiogram for Other Administrative Reason. Because it was his first audiogram at the Occupational Health Unit, the results were recorded on a DD 2215 shown in Exhibit 13. To facilitate entry of the audiology data, your NOHIMS manual contains an overlay to use when entering a DD 2215. When this overlay is placed over the form, the areas of the form which are not entered are blocked out. Exhibit 14 contains the DD 2215 shown in Exhibit 13 with the overlay photocopied onto it. After you have placed the overlay on the DD 2215, enter AOT, the code for an Audiogram for Other Administrative Reason, at the triple caret prompt.

>>> AOT
WRGS3 AUDIOGRAM FOR OTHER ADMINISTRATIVE REASON

9/25/84 PROVIDER: REED,WALTER,MD
WRGS3 AUDIOGRAM FOR OTHER ADMINISTRATIVE REASON

OK? Y

WRGQ6 DATE OF REFERENCE AUDIOGRAM
RESULTS >

REFERENCE AUDIOGRAM										ZIP CODE/APO 9 2 1 3 5			
DOD COMPONENT <input type="checkbox"/> A-ARMY M-MARINE CORPS <input type="checkbox"/> N-NAVY 1-OTHER DOD ACTIVITY <input type="checkbox"/> F-AIR FORCE					SERVICE COMPONENT <input type="checkbox"/> R-REGULAR G-NATIONAL GUARD <input type="checkbox"/> V-RESERVE 1-OTHER								
PERSONAL DATA													
SSN 5 5 8 6 3 4 9 2 0										LAST NAME-FIRST NAME-MIDDLE INITIAL COWREY, CHESTER			
SEX <input checked="" type="checkbox"/> M-MALE <input type="checkbox"/> F-FEMALE		DATE OF BIRTH year: 19 month: 3 day: 30			PAY GRADE, UNIFORMED SERVICES [] [] []			GRADE, CIVILIAN WL10		SERVICE DUTY OCCUPATION CODE [] [] []			
MAILING ADDRESS OF ASSIGNMENT 382 Workplace Road, San Diego, 92117													
LOCATION-PLACE OF WORK Supply Bldg 012						MAJOR COMMAND Supply				DUTY PHONE 7804			
AUDIOMETRY													
<input type="checkbox"/> 1. REFERENCE ESTABLISHED PRIOR TO INITIAL DUTY IN HAZARDOUS NOISE AREAS <input type="checkbox"/> 2. REFERENCE ESTABLISHED FOLLOWING EXPOSURE IN NOISE DUTIES <input type="checkbox"/> 3. REFERENCE RE-ESTABLISHED AFTER FOLLOWUP PROGRAM													
HEARING THRESHOLD LEVELS OF TEST FREQUENCIES RE: ANSI S3.6													
LEFT EAR						RIGHT EAR							
500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000		
10	20	15	20	65	75	10	10	10	25	55	65		
DATE OF AUDIOGRAM year: 19 month: 8 day: 4			DAY OF WEEK <input checked="" type="checkbox"/> 1 SUN 4 WED 7 SAT <input type="checkbox"/> 2 MON 5 THURS <input type="checkbox"/> 3 TUES 6 FRI			MIL TIME-DAY 0 8 3 1		HOURS SINCE LAST NOISE EXPOSURE 242		ENT PROBLEM AT TIME OF TEST <input type="checkbox"/> 1-NO 2-YES 3-UNKNOWN			
EXAMINER													
LAST NAME-FIRST NAME-MIDDLE INITIAL Technician, John Q						TRAINING CERT NO. 840619				SERVICE DUTY OCCUPATION CODE 0000		OFFICE SYMBOL 32546	
AUDIOMETER													
TYPE <input checked="" type="checkbox"/> 1 MANUAL <input type="checkbox"/> 2 SELF RECORDING (automatic) <input type="checkbox"/> 3 MICROPROCESSOR		MODEL 1707		MANUFACTURER Grason Stadler		SERIAL NUMBER 3253		LAST ELECTROACOUSTIC CALIB DATE year: 81 month: 4 day: 01					
PERSONAL HEARING PROTECTION													
TYPE USED <input type="checkbox"/> 1 SINGLE FLANGE (V51R) 5 NOISE MUFFS <input type="checkbox"/> 2 TRIPLE FLANGE 6 OTHER <input type="checkbox"/> 3 HAND FORMED EARPLUGS <input type="checkbox"/> 4 EAR CANAL CAPS				EARPLUGS ISSUED <input type="checkbox"/> 1 NO 2 YES <input type="checkbox"/> 3 PREVIOUSLY ISSUED		SIZE EARPLUGS <input type="checkbox"/> R <input type="checkbox"/> L 1 XS 2 S 3 M 4 L 5 XL		DOURLE PROTECTION USED <input type="checkbox"/> 1-NO 2-YES		GLASSES WORN (including goggles) <input type="checkbox"/> 1-NO 2-YES		FREQUENCY GLASSES WORN <input type="checkbox"/> 1 ALWAYS 2 SELDOM 3 N/A	
REMARKS HFHL Bilateral													
CONTENTS REVIEWED AND VALIDATED BY													
NAME OF REVIEWER (Signature) _____				SERVICE DUTY OCCUPATION CODE [] [] []		AUTOVON [] [] []		SSN [] [] [] [] [] []		OFFICE SYMBOL [] [] [] [] [] []			

Exhibit 13

DD 2215 - AUDIOLOGY RESULTS ENTRY (ENX, AOT, ECM)

REFERENCE AUDIOGRAM											
DOD COMPONENT					SERVICE COMPONENT						
<input checked="" type="checkbox"/> A-ARMY <input type="checkbox"/> N-NAVY <input type="checkbox"/> R-AIR FORCE <input type="checkbox"/> M-MARINE CORPS <input type="checkbox"/> 1-OTHER DOD ACTIVITY					<input type="checkbox"/> R-REGULAR <input type="checkbox"/> V-RESERVE <input type="checkbox"/> G-NATIONAL GUARD <input type="checkbox"/> 1-OTHER						
PERSONAL DATA											
SSN					LAST NAME-FIRST NAME-MIDDLE INITIAL						
558 63 49 20					LOWREY, CHESTER						
SEX		DATE OF BIRTH			PAY GRADE, UNIFORMED SERVICES		GRADE, CIVILIAN		SERVICE DUTY OCCUPATION CODE		
<input checked="" type="checkbox"/> M-MALE <input type="checkbox"/> F-FEMALE		19 33 03 28					WLT10				
MAILING ADDRESS OF ASSIGNMENT											
382 Workplace Road, San Diego, 92117											
LOCATION-PLACE OF WORK					MAJOR COMMAND			DUTY PHONE			
Supply Bldg 012					Supply			7804			
AUDIOMETRY											
<input type="checkbox"/> 1. REFERENCE ESTABLISHED PRIOR TO INITIAL DUTY IN HAZARDOUS NOISE AREAS <input type="checkbox"/> 2. REFERENCE ESTABLISHED FOLLOWING EXPOSURE IN NOISE DUTIES <input type="checkbox"/> 3. REFERENCE RE-ESTABLISHED AFTER FOLLOWUP PROGRAM											
HEARING THRESHOLD LEVELS OF TEST FREQUENCIES RE: ANSI S3.6											
LEFT EAR					RIGHT EAR						
500	1000	2000	5000	6000	500	1000	2000	3000	4000	6000	
10	20	15	20	65	75	10	10	10	25	55	65
DATE OF AUDIOGRAM		DAY OF WEEK		MIL TIME DAY		HOURS SINCE LAST NOISE EXPOSURE		HWT PROBLEM AT TIME OF TEST			
1 APR 84 01 25		3 1 SUN 4 WED 7 SAT		DOW 0 8 3 1		292 HLE		<input type="checkbox"/> 1-NO <input type="checkbox"/> 2-YES <input type="checkbox"/> 3-UNKNOWN			
EXAMINER											
LAST NAME-FIRST NAME-MIDDLE INITIAL					TRAINING CERT NO.		SERVICE DUTY OCCUPATION CODE		OFFICE SYMBOL		
Technician, John A					001 23 65 42		0000		32546		
AUDIOMETER											
TYPE		MODEL		MANUFACTURER		SERIAL NUMBER		LAST ELECTROACOUSTIC CALIB DATE			
<input type="checkbox"/> 1-MANUAL <input type="checkbox"/> 2-SELF-RECORDING (automatic) <input type="checkbox"/> 3-MICROPROCESSOR		1707		GRISON		3253		84 01 16			
PERSONAL HEARING PROTECTION											
TYPE USED		EAPPLUGS ISSUED		SIZE EAPPLUGS		DOUBLE PROTECTION USED		GLASSES WORN (including goggles)		FREQUENCY GLASSES WORN	
Line, HANE 10W 151R		1 NO 2 YES		XS 2S 3M 4L 5 XL		<input type="checkbox"/> 1-NO <input type="checkbox"/> 2-YES		<input type="checkbox"/> 1-NO <input type="checkbox"/> 2-YES		<input type="checkbox"/> 1-ALWAYS <input type="checkbox"/> 2-SELDO <input type="checkbox"/> 3-N/A	
<input checked="" type="checkbox"/> 3-HAND FORMED EAPPLUGS <input type="checkbox"/> 4-EAR CANAL CAPS		<input type="checkbox"/> 3-PREVIOUSLY ISSUED									
REMARKS											
HFL Bilateral											
Exhibit 14											
CONTENTS REVIEWED AND VALIDATED BY											
NAME OF REVIEWER (Signature)					SERVICE DUTY OCCUPATION CODE		AUTOVON		SSN		

Order of Entry

②

①

The encounter date shown by NOHIMS is correct, so we respond Y for Yes at the OK? prompt. The first member of this panel is Date of Reference Audiogram. At the RESULTS prompt, enter the date of the reference audiogram. This is found in the first box at the left of the second row of boxes in the middle of the form.

WRGQ6 DATE OF REFERENCE AUDIOGRAM
RESULTS > 9/25/84

The next three data items are found in the same row of boxes.

WRGY7 DAY OF WEEK REF AUDIOGRAM 2215 ONLY
RESULTS > ?

ENTER THE DAY OF THE WEEK AS ABBREVIATED TEXT
SUCH AS MON OR FRI. DO NOT ENTER THE CODE
NEXT TO THE DAY OF THE WEEK ON THE 2215 FORM.

NULL THROUGH THIS PROMPT IF YOU ARE ENTERING
A 2216 FORM (HEARING CONSERVATION DATA).
RESULTS > TUES

WRGF8 MIL TIME OF REF AUDIOGRAM 2215 ONLY
RESULTS > 0831

WRGN9 HOURS SINCE LAST EXPOSURE 2215 ONLY
RESULTS > 24

WRHH1 L EAR 500HZ REFERENCE
RESULTS >

We typed a question mark at the DAY OF WEEK prompt to find out how to enter the information. As with other laboratory tests, you may enter a question mark at each prompt to receive instructions on the proper format for the data entry. When data entry for these items is complete, we enter the

data on the line above these items. The entry of the results corresponding to the Hearing Threshold Levels for the left and right ears should look like the following.

WRHH1 L EAR 500HZ REFERENCE
RESULTS > 10

WRHF4 L EAR 1000HZ REFERENCE
RESULTS > 20

WRHD7 L EAR 2000HZ REFERENCE
RESULTS > 15

(Continued)

WRJN1 L EAR 3000HZ REFERENCE
 RESULTS > 20

 WRJL4 L EAR 4000HZ REFERENCE
 RESULTS > 65

 WRJJ7 L EAR 6000HZ REFERENCE
 RESULTS > 75

 WRKT1 R EAR 500HZ REFERENCE
 RESULTS > 10

 WRKR4 R EAR 1000HZ REFERENCE
 RESULTS > 10

 WRKP7 R EAR 2000HZ REFERENCE
 RESULTS > 10

 WRLZ1 R EAR 3000HZ REFERENCE
 RESULTS > 25

 WRLX4 R EAR 4000HZ REFERENCE
 RESULTS > 55

 WRLV7 R EAR 6000HZ REFERENCE
 RESULTS > 65

 WRHA0 L EAR 500HZ CURRENT
 RESULTS > IQ
 END OF LAB INPUT FOR THIS PATIENT? N

 >>>

When we got to the L EAR 500HZ CURRENT prompt, we entered an ^Q to tell NOHIMS that we were done entering information for this audiogram. NOHIMS will file the information we entered up to this point and will leave the rest of the codes unresulted. We responded N for No at the END OF LAB INPUT FOR THIS PATIENT? prompt and NOHIMS displayed the >>> prompt to indicate that we may proceed to the next laboratory result.

As with the other listcode panels, once you have entered a result for a prompt, you may not change it while in the listcode panel; you must enter the code for the individual test to change it. If you make a mistake while entering an audiogram, make a note of which result you entered incorrectly. Then when you are returned to the triple caret prompt, enter the code for that individual result. The codes for the individual prompts in the audiogram listcode panel can be found on the overlay. If we wanted to correct the Right Ear 500 result, for example, we would enter R5R at the triple caret prompt and the correct value at the RESULTS prompt.

The next audiogram for Chester Cowrey was recorded on a DD 2216, shown in Exhibit 15. Again, there is an overlay included with your manual to aid in entering the results. Exhibit 16 is the DD 2216 in Exhibit 15 with the overlay photocopied onto it. The reason for this audiogram was Excessive Noise Exposure, so enter ENX at the triple caret prompt. Enter Y for Yes at the OK? prompt if the date and provider match the date and provider displayed by NOHIMS.

>>> ENX
WRGK2 AUDIOGRAM FOR EXCESSIVE NOISE EXPOSURE

10/12/84 PROVIDER: SALK, JONAS, MD
WRGK2 AUDIOGRAM FOR EXCESSIVE NOISE EXPOSURE

OK? Y

WRGQ6 DATE OF REFERENCE AUDIOGRAM
RESULTS > 9/25/84

WRGY7 DAY OF WEEK REF AUDIOGRAM 2215 ONLY
RESULTS > ...NO ACTION

WRGF8 MIL TIME OF REF AUDIOGRAM 2215 ONLY
RESULTS > ...NO ACTION

WRGN9 HOURS SINCE LAST EXPOSURE 2215 ONLY
RESULTS > ...NO ACTION

The DATE OF REFERENCE AUDIOGRAM is found in the first box at the left of the second row of the data to be entered. The next three data items, DAY OF WEEK, MILITARY TIME, and HOURS SINCE LAST EXPOSURE, are only found on the DD 2215, so we nulled through the RESULTS prompt for these items. NOHIMS displayed the NO ACTION message to indicate that no data would be filed for these codes.

The number results for the audiometric data are entered next, beginning with the middle row of numbers. These results are for the Reference Audiogram and are entered in the same manner as for the DD 2215. Their entry would look as follows.

WRHH1 L EAR 500HZ REFERENCE
RESULTS > 10

WRHF4 L EAR 1000HZ REFERENCE
RESULTS > 20

WRHD7 L EAR 2000HZ REFERENCE
RESULTS > 15

WRJN1 L EAR 3000HZ REFERENCE
RESULTS > 20

(Continued)

HEARING CONSERVATION DATA										ZIP CODE/APO					
DOD COMPONENT <input type="checkbox"/> 1 A-ARMY N-NAVY F-AIR FORCE		M-MARINE CORPS 1-OTHER DOD ACTIVITY		SERVICE COMPONENT <input type="checkbox"/>		R-REGULAR V-RESERVE		G-NATIONAL GUARD 1-OTHER							
SSN 558634920		LAST NAME-FIRST NAME-MIDDLE INITIAL COWLEY, CHESTER				SEX <input checked="" type="checkbox"/> M F-FEMALE		DATE OF BIRTH 19/3/30/3/2/8							
PAY GRADE, UNIF SVCS [] [] []		GRADE, CIVILIAN WL10		SERVICE DUTY OCCUPATION CODE		MAILING ADDRESS OF ASSIGNMENT 382 Workplace Rd, San Diego, 92117									
LOCATION-PLACE OF WORK Supply Bldg-012						MAJOR COMMAND SUPPLY		DUTY PHONE 7804							
AUDIOMETRY															
PURPOSE <input type="checkbox"/> 1		1-90 DAY		2-ANNUAL		3-TERMINATION		4-OTHER							
AUDIOMETRIC DATA RE: ANSI S3.6				LEFT				RIGHT							
				500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE 19/8/4/10/1/2				10	20	20	20	60	70	10	10	20	25	55	60
REFERENCE AUDIOGRAM DATE 19/8/4/0/9/2/5				10	20	15	20	65	75	10	10	10	25	55	65
THRESHOLD SHIFT ++Poorer --Better					0	+5	0	-5			0	+10	0	0	
<input type="checkbox"/> 1-No Significant threshold shift 2-Yes (STS) 20dB or greater		STS NO		<input type="checkbox"/> Counsel <input type="checkbox"/> Return to duty <input type="checkbox"/> Retest in 12 mo.		<input type="checkbox"/> Validated by reviewer <input type="checkbox"/> Orig in health record <input type="checkbox"/> Send copy to registry		STS YES		<input type="checkbox"/> Notify supervisor <input type="checkbox"/> Followup No. 1 after minimum 15 hours noise free					
NAME OF EXAMINER (Last, first, MI) Examiner, Mary J.				TRAINING CERT NO. 841259		SSN 036421957		SERVICE DUTY OCCUPATION CODE 0006		OFC SYMBOL 32546					
TYPE <input type="checkbox"/> 1-Manual 2-Self-recording (auto) 3-Microprocessor		MODEL 1707		MANUFACTURER Grason Stadler		SERIAL NO. 3253		LAST ELECTROACOUSTIC CALIB DATE 19/8/4/0/1/1/6							
FOLLOWUP NO. 1 <input type="checkbox"/> Minimum 15 hours noise free															
AUDIOMETRIC DATA RE: ANSI S3.6				LEFT				RIGHT							
				500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE [] [] [] [] [] []															
REFERENCE AUDIOGRAM DATE [] [] [] [] [] []															
THRESHOLD SHIFT ++Poorer --Better															
<input type="checkbox"/> 1-No Significant threshold shift 2-Yes (STS) 20dB or greater		STS NO		<input type="checkbox"/> Counsel <input type="checkbox"/> Return to duty <input type="checkbox"/> Retest in 12 mo.		<input type="checkbox"/> Validated by reviewer <input type="checkbox"/> Orig in health record <input type="checkbox"/> Send copy to registry		STS YES		<input type="checkbox"/> Notify Supervisor <input type="checkbox"/> Cleared by medical reviewer before Followup No. 2					
NAME OF EXAMINER (Last, first, MI)				TRAINING CERT NO.		SSN		SERVICE DUTY OCCUPATION CODE		OFC SYMBOL					
TYPE <input type="checkbox"/> 1-Manual 2-Self-recording (auto) 3-Microprocessor		MODEL		MANUFACTURER		SERIAL NO.		LAST ELECTROACOUSTIC CALIB DATE [] [] [] [] [] []							
FOLLOWUP NO. 2 <input type="checkbox"/> Minimum 40 hours noise free since Followup No. 1															
AUDIOMETRIC DATA RE: ANSI S3.6				LEFT				RIGHT							
				500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE [] [] [] [] [] []															
REFERENCE AUDIOGRAM DATE [] [] [] [] [] []															
THRESHOLD SHIFT ++Poorer --Better															
Significant threshold shift (STS) 20dB or greater <input type="checkbox"/> 1-No 2-Yes		STS NO		<input type="checkbox"/> Counsel <input type="checkbox"/> Return to duty <input type="checkbox"/> Retest in 12 mo.		<input type="checkbox"/> Validated by reviewer <input type="checkbox"/> Orig in health record <input type="checkbox"/> Send copy to registry		STS YES		<input type="checkbox"/> Refer to apro directive <input type="checkbox"/> Requires medical disposition <input type="checkbox"/> Validated by reviewer <input type="checkbox"/> Orig in health record <input type="checkbox"/> Send copy to registry					
NAME OF EXAMINER (Last, first, MI)				TRAINING CERT NO.		SSN		SERVICE DUTY OCCUPATION CODE		OFC SYMBOL					
TYPE <input type="checkbox"/> 1 Manual 2 Self-recording (auto) 3-Microprocessor		MODEL		MANUFACTURER		SERIAL NO.		LAST ELECTROACOUSTIC CALIB DATE [] [] [] [] [] []							
REVIEWED & VALIDATED BY:				SERVICE DUTY OCCUPATION CODE		AUTOVON		SSN		OFC SYMBOL					

4-01
Exhibit 16

DD 2216 - AUDIOLOGY RESULTS ENTRY (ENX, AOT, ECH)

HEARING CONSERVATION DATA										
DD COMPONENT		A. ARMY N. NAVY M. MARINE CORPS O. OTHER DOD ACTIVITY		SERVICE COMPONENT		R. REGULAR V. RESERVE		N. NATIONAL GUARD O. OTHER		
SSN		LAST NAME - FIRST NAME - MIDDLE INITIAL				SEX		DATE OF BIRTH		
5681624920		COWREY, CHESTER				M		1913/3/21		
PAY GRADE, UMF SVCS		GRADE, CIVILIAN		SERVICE DUTY OCCUPATION CODE		MAILING ADDRESS OF ASSIGNMENT				
		W-10				382 Workplace Rd, San Diego, 12112				
LOCATION - PLACE OF WORK				MAJOR COMMAND		DUTY PHONE				
Supply Bldg - 012				Supply		7804				
AUDIOMETRY										
PURPOSE <input checked="" type="checkbox"/> 1 - 30 DAY <input type="checkbox"/> 2 - ANNUAL <input type="checkbox"/> 3 - TERMINATION <input type="checkbox"/> 4 - OTHER										
AUDIOMETRIC DATA RE: ANSI S3.6				LEFT						
CURRENT AUDIOGRAM DATE 19/8/4 month day				500	1000	2000	3000	4000	6000	RIGHT
REFERENCE AUDIOGRAM DATE 14/8/4 month day				500	1000	2000	3000	4000	6000	
THRESHOLD SHIFT				10	20	20	20	60	70	
				10	20	15	20	65	75	
				0	+5	0	-5	0	+10	
1. No Significant threshold shift (STS) 20dB or greater				STS NO		Counsel		Validated by reviewer		
2. Yes				STS YES		Return to duty		Orig in health record		
NAME OF EXAMINER (Last, first, MI)				TRAINING CERT NO.		SSN		SERVICE DUTY OCCUPATION CODE		
Examiner, Mary J.				8425103642		1954		32546		
TYPE		MODEL		MANUFACTURER		SERIAL NO.		LAST ELECTROACOUSTIC CALIB DATE		
1. Manual 2. Self-recording (auto) 3. Microprocessor		1707		Garcon Stalder		3353		14/8/4 month day		
FOLLOWUP NO. 1 Minimum 15 hours noise free										
AUDIOMETRIC DATA RE: ANSI S3.6				LEFT						
CURRENT AUDIOGRAM DATE				500	1000	2000	3000	4000	6000	
REFERENCE AUDIOGRAM DATE				500	1000	2000	3000	4000	6000	
THRESHOLD SHIFT				RIGHT						
				500 1000 2000 3000 4000 6000						
1. No Significant threshold shift (STS) 20dB or greater				STS NO		Counsel		Validated by reviewer		
2. Yes				STS YES		Return to duty		Orig in health record		
NAME OF EXAMINER (Last, first, MI)				TRAINING CERT NO.		SSN		SERVICE DUTY OCCUPATION CODE		
Major General Edward J. (first, MI)										
TYPE		MODEL		MANUFACTURER		SERIAL NO.		LAST ELECTROACOUSTIC CALIB DATE		
1. Manual 2. Self-recording (auto) 3. Microprocessor										
FOLLOWUP NO. 2 Minimum 40 hours noise free since Followup No. 1										
AUDIOMETRIC DATA RE: ANSI S3.6				LEFT						
CURRENT AUDIOGRAM DATE				500	1000	2000	3000	4000	6000	
REFERENCE AUDIOGRAM DATE				500	1000	2000	3000	4000	6000	
THRESHOLD SHIFT				RIGHT						
				500 1000 2000 3000 4000 6000						
1. No Significant threshold shift (STS) 20dB or greater				STS NO		Counsel		Validated by reviewer		
2. Yes				STS YES		Return to duty		Orig in health record		
NAME OF EXAMINER (Last, first, MI)				TRAINING CERT NO.		SSN		SERVICE DUTY OCCUPATION CODE		
TYPE		MODEL		MANUFACTURER		SERIAL NO.		LAST ELECTROACOUSTIC CALIB DATE		
1. Manual 2. Self-recording (auto) 3. Microprocessor										
REVIEWED & VALIDATED BY: SERVICE DUTY OCCUPATION CODE AUTOVON SSN OFF SYMBOL										

DD FORM 2216
1 SEP 79

Line up with bottom margin of DD 2216

S/N 0102-LF-002-2160

WRJL4 L EAR 4000HZ REFERENCE
RESULTS > 65

WRJJ7 L EAR 6000HZ REFERENCE
RESULTS > 75

WRKT1 R EAR 500HZ REFERENCE
RESULTS > 10

WRKR4 R EAR 1000HZ REFERENCE
RESULTS > 10

WRKP7 R EAR 2000HZ REFERENCE
RESULTS > 10

WRLZ1 R EAR 3000HZ REFERENCE
RESULTS > 25

WRLX4 R EAR 4000HZ REFERENCE
RESULTS > 55

WRLV7 R EAR 6000HZ REFERENCE
RESULTS > 65

The Current Audiogram results, the first row of numbers, are entered next. The format is the same as for the Reference Audiogram results.

WRHA0 L EAR 500HZ CURRENT
RESULTS > 10

WRHY3 L EAR 1000HZ CURRENT
RESULTS > 20

WRHW6 L EAR 2000HZ CURRENT
RESULTS > 20

WRHT9 L EAR 3000HZ CURRENT
RESULTS > 20

WRJD3 L EAR 4000HZ CURRENT
RESULTS > 60

WRJB6 L EAR 6000HZ CURRENT
RESULTS > 70

WRJZ9 R EAR 500HZ CURRENT
RESULTS > 10

WRKJ3 R EAR 1000HZ CURRENT
RESULTS > 10

(Continued)

WRKG6 R EAR 2000HZ CURRENT
RESULTS > 20

WRKE9 R EAR 3000HZ CURRENT
RESULTS > 25

WRLP3 R EAR 4000HZ CURRENT
RESULTS > 55

WRLM6 R EAR 6000HZ CURRENT
RESULTS > 60

The last set of numbers are the Threshold Shifts. These are the third row of numbers. These numbers are entered in the format of either -N or 0 or +N. When entering the other rows of numbers, we entered a total of twelve numbers. The 500HZ and 6000HZ threshold shifts are not entered, so the first item prompted for is L EAR 1000HZ THRESHOLD SHIFT as shown below.

WRHN5 L EAR 1000HZ THRESHOLD SHIFT
RESULTS > 0

WRHL8 L EAR 2000HZ THRESHOLD SHIFT
RESULTS > +5

WRJW2 L EAR 3000HZ THRESHOLD SHIFT
RESULTS > 0

WRJT5 L EAR 4000HZ THRESHOLD SHIFT
RESULTS > -5

WRKZ5 R EAR 1000HZ THRESHOLD SHIFT
RESULTS > 0

WRKX8 R EAR 2000HZ THRESHOLD SHIFT
RESULTS > +10

WRLG2 R EAR 3000HZ THRESHOLD SHIFT
RESULTS > 0

WRLE5 R EAR 4000HZ THRESHOLD SHIFT
RESULTS > 0

>>>

This completes the data entry for a DD 2216. As with the other listcode panels, if you make an error while entering data, you must enter the individual code after the listcode panel is completed to change the result. The codes for the individual items can be found in the overlay.

MULTIPLE RESULT TESTS

The next laboratory test for Chester Cowrey, the Differential with Morphology, is a listcode panel with three members. The first member, Differential Count, is a multiple result test. The actual number of results reported for the Count can vary. When the Count is triggered by the Differential with Morphology listcode panel, NOHIMS will give a series of prompts for the counts most commonly reported. If the lab chit has additional counts, they are entered in response to the OTHER RESULTS prompt. Exhibit 11 on page 4-47 shows a lab chit with a Differential with Morphology test result. Enter DFF at the triple caret prompt to begin entering result data for the Differential with Morphology.

>>> DFF
WRDR5 DIFFERENTIAL WITH MORPHOLOGY

9/25/84 PROVIDER: REED, WALTER, MD
WRDR5 DIFFERENTIAL WITH MORPHOLOGY

OK? Y

MNDZ3 DIFFERENTIAL COUNT

NEUTROBANDS >
NEUTROPHILS SEGS > 53
LYMPHOCYTES > 41 <ABNORMAL>
EOSINOPHILS > 6
BASOPHILS > -
EOSINOPHILS > 4
BASOPHILS > -
MONOCYTES >

OTHER RESULTS > ?

IF A CELL TYPE ON THE LAB CHIT WAS NOT PROMPTED FOR IN THE ABOVE SEQUENCE, ENTER THE FIRST TWO LETTERS OF THE CELL TYPE OR THE CORRESPONDING ONE LETTER CODE. (TYPE "L" TO LIST THE CELL TYPES RECOGNIZED BY THE PROGRAM WITH THEIR CORRESPONDING ONE LETTER CODES). IF THE PROGRAM DOES NOT RECOGNIZE THE NAME YOU TYPE IN,

NOTIFY YOUR SYSTEM MANAGER.

^ GOES TO PREVIOUS QUESTION

(ESC) GOES TO NEXT QUESTION

^Q GETS OUT OF FUNCTION

- DELETES ENTRY

OTHER RESULTS >

The first series of prompts requested values to be entered for the usual set of results. If there is no value for one of the results, simply press RETURN to null through that prompt. If you make an error in entering the usual set of results, you may use the ^ command to return to the appropriate prompt(s) and then enter the correct result, as we did for

EOSINOPHILS. The last prompt asks for OTHER RESULTS. As indicated by the message NOHIMS displayed when we entered a question mark, we can enter values for other cell types by entering their name or their corresponding one letter code. If you type ^L at the OTHER RESULTS prompt, NOHIMS will display a list of all of the white blood cell types that NOHIMS accepts. The OTHER RESULTS prompt appears again after the list has been displayed, and then you can enter the appropriate cell name or the letter code for the cell. Immature lymphocytes are the same as lymphoblasts and the corresponding code is K, so we will enter K at the OTHER RESULTS prompt. NOHIMS will display the cell name you have entered and prompt for the number of cells of that type. You may then enter the number of cells of that type as shown below.

```
OTHER RESULTS > K
LYMPHOBLASTS > 2  <ABNORMAL>
```

```
OTHER RESULTS >
```

You may also correct values for the usual types of cells at the OTHER RESULTS prompt by entering their name or corresponding code. After you are done entering other types of cells or correcting the usual types of cells, null through the OTHER RESULTS prompt to indicate completion of the results entry for this test. NOHIMS then displays a Normal or Abnormal status in brackets, indicating the status of the differential white blood cell count for this patient.

```
OTHER RESULTS >  <ABNORMAL>
```

If fewer than the standard 100 cells counted are entered, NOHIMS will at this point indicate the total number of cells entered and ask if the number is OK. If NOHIMS queries you in this fashion, you should check that all result values on the lab report have been entered correctly. If they were entered correctly, enter Y for Yes as shown below.

```
OTHER RESULTS >
```

```
97 CELLS COUNTED  OK? > Y  <ABNORMAL>
```

If at any point the total number of cells entered goes over 100, NOHIMS will immediately display a TOTAL EXCEEDS 100 message. Again, you should check that the result values on the lab report have been entered correctly. If you get this message and have entered the data on the laboratory report correctly, complete the entry as usual; the message is merely a warning to be sure that you are entering the data correctly. At the end of entry, NOHIMS will indicate the total number of cells and ask if the number is OK as in the above example. If your entries are correct, enter Y for Yes. NOHIMS will add a message to the patient's file that the number of cells counted is greater than 100.

After entering the Differential Count, NOHIMS will prompt for the next member of the Differential with Morphology listcode panel, PLATELETS. Enter the results on the lab chit as shown below.

```
MNAY5 PLATELETS
RESULTS > ADQ <NORMAL>
```

```
MNAQ4 RBC MORPHOLOGY
RESULTS > WNL <NORMAL>
```

>>>

We entered exactly what appeared on the lab chit at the RESULTS prompts. NOHIMS compared it to a list of normal results and then displayed the status in brackets. We have now completed the Differential with Morphology panel.

The next laboratory test to be entered is the Urinalysis. The process for entering the results for this test is the same as for the Differential Count. NOHIMS will prompt for the most common results and then prompt for OTHER RESULTS. The entry of the Urinalysis results shown in Exhibit 17 would appear as follows.

```
>>> UA
      WNBQ1 URINALYSIS
```

```
9/25/84          PROVIDER: REED,WALTER,MD
WNBQ1 URINALYSIS
```

```
OK? Y
WNBQ1 URINALYSIS
```

```
COLOR > STRAW
APPEARANCE >
```

When entering a nonnumeric result, you only need to enter the first letter of the result. NOHIMS will automatically fill in the rest of the letters. In the example above, we entered S and NOHIMS filled in with TRAW. There are a variety of acceptable answers for each prompt. If you type a question mark (?) at the prompt, NOHIMS will display a list of the acceptable results.

The second data item that NOHIMS prompts for is APPEARANCE. This result does not appear as a separate line item on the laboratory chit; instead, the technicians usually put a slash after the COLOR followed by the APPEARANCE. Two of the APPEARANCE results begin with the letter C, CLEAR and CLOUDY. Therefore, to enter CLOUDY as an APPEARANCE, you must enter O for OPAQUE. If you enter C for CLOUDY, NOHIMS will file CLEAR. This is noted in the question mark response for APPEARANCE. Proper entries for APPEARANCE and the rest of the urinalysis results are shown below.

APPEARANCE > CLEAR
SPECIFIC GRAVITY > 1.026

UROBILINOGEN > WNL
OCCULT BLOOD > NEGATIVE

BILE > NEGATIVE
KETONES > NEGATIVE
GLUCOSE > +
PROTEIN > NEGATIVE
PH > 6.0
WHITE BLOOD CELLS > 20-25
RED BLOOD CELLS > 0
EPITHELIAL CELLS > 0
BACTERIA > RARE
CRYSTALS > 0
MUCUS > MODERATE
NITRITE > ^
MUCUS <MODERATE> ALOT
NITRITE > NEGATIVE

OTHER RESULTS > <ABNORMAL>

>>>

Note that NOHIMS did not prompt for casts. If the patient has casts, enter this result at the OTHER RESULTS prompt. At the MUCUS prompt, we entered M for MANY; NOHIMS filled in with MODERATE. We used the ^ command to return to the MUCUS prompt and entered A for ALOT, the synonym NOHIMS uses for MANY. After we pressed RETURN at the OTHER RESULTS prompt to indicate that we were done entering results, NOHIMS assigned a status to the entire test and displayed this status in brackets. We pressed RETURN to accept the status and return to the triple caret prompt.

The last example of a multiple result test is the entry of result data for Pulmonary Function Test. Exhibit 18 shows an example of the page in the patient's chart which has the Pulmonary Function Test results. The first five items that are entered are found on a printout which is stapled to the page. The last item and comments are located at the top of the page.

There are two kinds of Pulmonary Function Tests that may be ordered--- Pulmonary Function Test Asbestos and Pulmonary Function Test Other Than Asbestos. If the patient's PEDS/PEX form is handy, you may look there to see which one was ordered and enter the appropriate code. If it is not handy, you will have to enter the code for the Pulmonary Function Test Other Than Asbestos (PFTO) first. If NOHIMS does not find an ordered Pulmonary Function Test Other Than Asbestos for the correct date, then enter the code for the Pulmonary Function Test Asbestos (PFTA) to see if it was the one that was ordered. At this point you should also look at the top of the page to see whether there are comments to be entered as free text. If so, you must type an asterisk (*) after the PFTA or PFTO code. In our example, there are no comments, so we will enter just the code without the asterisk.

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
OCT 12 1984	EVALUATION FOR UTILIZING RESPIRATOR		
AGE: 51	PFT: <u>NORMAL</u> ABNORMAL QUESTIONABLE		
HT: 5' 11 1/2"	FACIAL DEFORMITIES (including beard) <u>none</u>		
WT: 190	DENTURES: YES <u>NO</u>		
SEX: <u>MALE</u>			
RACE: <u>CAUC</u>			
TEMP: 97.			
B.P.: 120/70			
PULMONARY HISTORY: (asthma, bronchitis, URI's, etc)			
<u>No asthma, no bronchitis</u>			
<u>Smoker pack a day (average)</u>			

SPIROTECH 200
 10/12/84
 TEMP 200 170000
 ID 552634920
 STARS 711N M W
 NORM FEU1 3.66
 NORM FUC 5.17
 3 UNLID OF 3
 FEU1 CRIT= 5%
 FUC CRIT= 5%

BEST TESTS
 FEU1= 3.70 101%
 FUC = 4.45 86%
 FEU1 FUC= 0.83
 SEM CODE=FO OK

TEST#1 13:24
 FEU1= 3.70 101%
 FUC = 4.45 86%
 FEU1 FUC= 0.83

TEST#2 13:25
 FEU1= 3.56 91%
 FUC = 4.10 74%
 FEU1 FUC= 0.87

TEST#3 13:25
 FEU1= 3.47 95%
 FUC = 4.18 83%

CARDIAC HISTORY: (EKG, if not seen)		<u>None</u>
QUALIFIED:	<u>YES</u>	NO
SIGNATURE <u>Jones Hall, MD</u>		

this Space

Exhibit 18

PATIENT NAME (Last, First, Middle Initial)		SEX
COWKEY, CHESTER C		M
YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	DEPARTMENT/STATUS/DEPT/SEVIC
1933		
SPONSOR'S NAME		GRADE
		WL-10
SSAN OR IDENTIFICATION NO.		ORGANIZATION
552-63 4920		NARE

PULMONARY FXN TEST

CHRONOLOGICAL RECORD OF MEDICAL CARE
 Standard Form 88A

>>> PFTO
WQA22 PULMONARY FXN TEST OTHER THAN ASBESTOS

DATE >

>>> PFTA
WQFT1 PULMONARY FXN TEST ASBESTOS

10/12/84 PROVIDER: SALK, JONAS, MD
WQFT1 PULMONARY FXN TEST ASBESTOS

OK? Y
WQFT1 PULMONARY FXN TEST ASBESTOS

When NOHIMS could not find an ordered Pulmonary Function Test Other Than Asbestos, it prompted for the date of the test. This indicated that there was no ordered Pulmonary Function Test Other Than Asbestos in the patient's files. We pressed RETURN at the DATE prompt to return to the triple caret prompt and entered PFTA for the Pulmonary Function Test Asbestos. NOHIMS then found an ordered PFTA on the correct date. We entered Y for Yes to enter the results.

The printout from the spirometer has results from several tests. The results that you should enter are found in the top half of the printout under the label "BEST TESTS". The FEV1 and FVC are the numbers directly to the right of the equals sign; the FEV1% and FVC% are to the right of these numbers. You do not need to enter the percent signs. The entry of the first four data items looks like the following.

FORCED EXPIRATORY VOLUME IN 1 SECOND FEV1 > 3.70
FEV1 PERCENT > 101
FORCED VITAL CAPACITY FVC > 4.45
FVC PERCENT > 86

The next data item, the FEV1/FVC ratio, is found below the FEV1 and FVC results. When entering this value, you do not need to enter the leading zeros in front of the decimal place.

FEV1/FVC > .83
PHYSICIAN EVALUATION > NORMAL

OTHER RESULTS > <NORMAL>

The Physician Evaluation is found at the top of the patient's chart page. The physician should circle one of the following evaluations: NORMAL, ABNORMAL, OR QUESTIONABLE. If the physician did not circle one of these evaluations, null through this prompt. If the physician circled ABNORMAL or

QUESTIONABLE, there should be comments written near the circled result. These comments are entered when NOHIMS prompts for free text in response to the asterisk that you entered with the code for the test. Entry of comments would look like the following.

PHYSICIAN EVALUATION > ABNORMAL

OTHER RESULTS > <ABNORMAL>

1> MILD OBSTRUCTIVE DISEASE

2>

>>>

This completes the lab results entry for our example patient, Chester Cowrey. Type ^ or null through the >>> prompt to tell NOHIMS that you are done entering lab results for this patient. NOHIMS will ask if you are at the END OF LAB INPUT FOR THIS PATIENT? Enter Y for Yes to move on; enter N for No if you wish to enter more lab results for this same patient. At the ENTER LAB RESULTS FOR PATIENT prompt, you may either enter another patient's identifying information or null through the prompt to move on to other system options.

>>>

END OF LAB INPUT FOR THIS PATIENT? Y

ENTER LAB RESULTS FOR PATIENT >

ENTER MEDICAL DATA OPTION >

MEDICAL EDIT

Periodically, it may be necessary to change or edit a patient's medical record. The need for this revision may be attributable to errors or omissions in the initial data entry process, or to subsequent notes and modifications made by a physician. The procedures for the MEDICAL EDIT option are very similar to the ENCOUNTER option, except that some informational prompts are added which relate to the editing or changes to be made.

Changes to an item that is already recorded in a patient's medical record are made by re-entering the item as it should appear in the record. Remember, when an entry is corrected in the ENCOUNTER option, you simply re-enter the item. The process is the same for the MEDICAL EDIT option. However, in the MEDICAL EDIT option, NOHIMS gives you an opportunity to choose between the old and new entry for each item. If an item is to be added to an encounter, the procedure is exactly the same as in the ENCOUNTER option.

In the MEDICAL EDIT option, changes are made for one encounter at a time. After the patient's name (or social security number) and encounter date are entered, NOHIMS displays the Header information for the encounter and asks for verification. The Header data may be edited using standard NOHIMS procedures. After the Header data are changed or accepted as displayed, the triple caret prompt (>>>) appears, allowing changes to be made to the medical and work items. Editing is completed for an individual encounter by responding Y for Yes to the EDITING COMPLETE prompt. The patient's medical record is not updated until this point is reached.

To demonstrate the MEDICAL EDIT option, the following data edit list itemizes the changes to be made to Encounters for Jason Pilot and Cynthia Rigger.

ENCOUNTER EDIT 1

Name of Patient	Jason P. Pilot
Unit Number (SSN)	523-49-2000
Date of Encounter	12/15/84
Care Provider	Dr. Reed
CHANGES TO HEADER DATA:	None

(Continued)

CHANGES TO MEDICAL AND WORK DATA:

Correct:

Height was recorded as 75 inches; it should be 71 inches.

HT HEIGHT

Add:

RR RESPIRATORY RATE Rate - 18

Comment - RATE SLIGHTLY HIGH, FOLLOW UP

Forgotten in data entry.

Add Comment:

401 ESSENTIAL HYPERTENSION

Add the following free text comment - FOLLOW UP

Make no other changes to the entry.

Add:

A/HXB-O HEART EXAMINATION WAS ABNORMAL (OTHER HEART)

Comment - MITRAL VALVE REPLACED, 1977

This item was omitted from the encounter form.

Change:

EYX-N EYE EXAMINATION WAS NORMAL

Delete the free text comment entered with the code; it
was incorrectly recorded on the encounter form.

ENCOUNTER EDIT 2

Name of Patient	Cynthia T. Rigger
Unit Number (SSN)	397-20-1465
Date of Encounter	11/26/84
Care Provider	Dr. Salk

CHANGES TO HEADER DATA:

Add Second Provider: F. Nightingale

Change Visit Classification to:

3 CIVILIAN UNSCHEDULED PHYSICAL EXAM

CHANGES TO MEDICAL AND WORK DATA:

Change Results of Urinalysis:

UA URINALYSIS

SPECIFIC GRAVITY From 1.008 to 1.035

PROTEIN From NEGATIVE to 1+

Change:

JC-F to JC-E PHYSICAL EXAMINATION IS FOR JOB CERTIFICATION
(FOR CRANE OR CONSTRUCTION OPERATOR OR RIGGER)
Entered incorrectly.

Add:

UXX UPPER EXTREMITIES XRAY

DSP-D DISPOSITION: RESTRICTION(S): LIFTING OR PUSHING OR
PULLING OR CARRYING

CYN HAZARD SURV CYANIDES

Delete:

HSO HAZARD SURV OTHER HAZARDOUS AGENT: CYANIDE
Entered as an other hazardous surveillance by mistake.
CYN is the code for Hazard Surveillance for Cyanides.

Select the MEDICAL EDIT option and enter the first patient's name or unit number (SSN).

SYSTEM OPTION > ENTER MEDICAL DATA

ENTER MEDICAL DATA OPTION > MEDICAL EDIT

EDIT ENCOUNTER FOR PATIENT > 523-49-2000 - PILOT, JASON P (M) 6/13/54

DATE OF ENCOUNTER >

Next, enter the date of the encounter, and NOHIMS will display the Header information for the specified date.

DATE OF ENCOUNTER > 12/15 (12/15/84)

1. DATE: 12/15/84

PROVIDER: REED, WALTER, MD

SITE: A NORTH ISLAND

TYPE: F PERIODIC EXAM

VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM

EDIT THIS ENCOUNTER? > Y

EDIT HEADER INFORMATION? > N

>>>

The header information displayed matched the information we had for Jason Pilot, so we entered Y for Yes at the EDIT THIS ENCOUNTER? prompt. For this encounter, there are no changes to be made to the Header data, so an N for No response was given to the EDIT HEADER INFORMATION? prompt, and the triple caret prompt >>> appeared so that we could make changes to the medical and work items.

The first correction to be made is for the patient's height; the code is entered for height. Remember, when HT (a Physical Finding) is entered in Encounter entry, NOHIMS expects a value to be entered; consequently, no asterisk is necessary at the the end of the code. The same convention applies to MEDICAL EDIT entries.

>>> HT

CAJCL HEIGHT

OLD VALUE: CAJCL HEIGHT

75

EDIT? Y

ENTER HEIGHT > 71

>>>

After the code was entered, NOHIMS echoed back the internal code and full name. Then, the item as it was recorded in the patient's record was displayed; finally NOHIMS asked if this item was to be edited. A Y for Yes was entered, and NOHIMS displayed a prompt for the new value to be entered. The editing was complete after the new value was entered, as indicated by the triple caret prompt.

For some reason, the next item for this encounter---RESPIRATORY RATE---was not entered into the patient's record. Because a comment is to be included with this entry, enter the code with an asterisk.

```
>>> RR*
      CAFL1 RESPIRATORY RATE
ENTER RESPIRATORY RATE > 18
1> RATE SLIGHTLY HIGH, FOLLOW UP
2>

>>>
```

Notice that this entry is exactly the same as if the item had been entered in the ENCOUNTER option. When the code was entered followed by the asterisk, NOHIMS echoed back the name. Because this item is a new entry for the encounter, there was no display of an OLD VALUE. Also, there is no need for the EDIT? prompt. After the respiratory rate was entered, NOHIMS prompted for the first line of free text. The prompt for the second line of text was nulled through, which completed the entry.

The next correction for this encounter adds a comment to the diagnosis of hypertension. The code for hypertension is entered with an asterisk to indicate that a free text comment is to be entered.

```
>>> 401*
      FLBG8 ESSENTIAL HYPERTENSION
OLD VALUE: FLBG8 ESSENTIAL HYPERTENSION
STATUS: MAJOR PRESUMPTIVE
SEE PHYSICAL FINDINGS
EDIT? Y
FILE, EDIT, OR IGNORE TEXT > E
INSERT, CHANGE, OR DISPLAY TEXT > I
INSERT AFTER LINE > 1
1> - FOLLOW UP
2>
INSERT, CHANGE, OR DISPLAY TEXT > D

1> SEE PHYSICAL FINDINGS - FOLLOW UP
INSERT, CHANGE, OR DISPLAY TEXT >
FILE, EDIT, OR IGNORE TEXT > F

>>>
```

In response to the code for hypertension, NOHIMS displayed the information that was recorded for the code in the patient's record. This information includes the statuses of Major and Presumptive, and the free text reference to Physical Findings. Notice that we did not enter the status codes as part of our edit entry. Because we said Y for Yes to the EDIT? prompt, the two status codes will be removed from the record.

NOHIMS then asked if we wished to FILE, EDIT, OR IGNORE TEXT. At this point, both options FILE and IGNORE will leave the free text comment as it was in the original entry. Generally, when FILE is chosen, NOHIMS will either file the edited version of the free text comment or the original free text if no changes have been made. If IGNORE is selected, NOHIMS ignores any editing of the free text and simply leaves the free text as it was originally. As we have not made any changes in the free text yet, both options cause the original text to remain. We wish to add a comment, so we selected E for EDIT.

NOHIMS then asked if we wanted to INSERT, CHANGE, OR DISPLAY TEXT. DISPLAY displays the free text comment as it stands at that moment (including edits if you have made any). INSERT allows you to insert information at the end of a line that you choose. If the line is full, NOHIMS will insert the new text at the beginning of the next line.

CHANGE allows you to change either part of or the entire content of the line you selected. When you select CHANGE, NOHIMS asks what line number you wish to change and then prints the line as it is stored. You may indicate that you wish to delete all of the characters that are stored at that line number by pressing the CONTROL key and the U key at the same time. NOHIMS will not erase the text displayed on the screen, but it has eliminated it from the new version of the text to be filed at that line number. You may then type in the text you wish to be stored at that line number. You may also delete part of a line of text by pressing the delete key the same number of times as the number of characters you wish to delete. Again, the display will not show that the characters have been deleted from the text, but NOHIMS has eliminated that number of characters from the end of the line of text.

We wished to add a comment, so we entered I for INSERT and 1 to start inserting at the end of line 1. When we entered the FOLLOW UP comment, we put a dash and a space in front of the text to offset it from the other free text on line 1. Then we nulled through the prompt for a second line of text. At the next INSERT, CHANGE, OR DISPLAY TEXT prompt, we entered D for DISPLAY to check our work. We nulled through the next prompt to indicate we were finished with editing and then entered F for FILE at the FILE, EDIT, OR IGNORE TEXT prompt. NOHIMS will file the free text as we saw it at the DISPLAY option. We could have re-edited the free text by selecting E for EDIT. If we had decided to leave the free text as it was originally, we could have entered I for IGNORE, and NOHIMS would have ignored our addition and left the free text comment in the patient's record as just SEE PHYSICAL FINDINGS.

You can verify that the status codes were deleted by completing the edit for this encounter and then selecting the same encounter for editing again. Then, when 401 is entered, NOHIMS will not display the statuses. If you are

practicing at a terminal, you can try this out. Null through the >>> prompt and respond Y for Yes to the EDITING COMPLETE? prompt. Then re-enter the patient's social security number and encounter date.

>>>

EDITING COMPLETE? Y

EDIT ENCOUNTER FOR PATIENT > 523-49-2000 - PILOT,JASON P (M) 6/13/54
RECORD BUSY

EDIT ENCOUNTER FOR PATIENT >

What happened here? NOHIMS had not completed updating the patient's record; so you must wait a little while before you can access the record again. Try entering Jason Pilot's social security number again after a few minutes.

EDIT ENCOUNTER FOR PATIENT > 523-49-2000 - PILOT,JASON P (M) 6/13/54
DATE OF ENCOUNTER > 12/15 (12/15/84)

After the Header data are displayed, the following prompts appear.

EDIT THIS ENCOUNTER? > Y
EDIT HEADER INFORMATION? N

>>>

Now, enter the code for hypertension and omit the asterisk.

>>> 401
FLBG8 ESSENTIAL HYPERTENSION
OLD VALUE: FLBG8 ESSENTIAL HYPERTENSION
SEE PHYSICAL FINDINGS - FOLLOW UP
EDIT?

You can see that NOHIMS now displays the item exactly as it was recorded in the MEDICAL EDIT option. The edited comment is included, but the statuses are not. If we respond Y for Yes to the EDIT? prompt, NOHIMS will not ask for a free text entry because there is no asterisk at the end of the code. Thus, the comments also will be deleted and only the diagnosis, without a status or comment, will remain in the patient's record.

It is important to remember that you cannot simply add information to a previously entered code. It is necessary that the edited entry contain all of the information that is supposed to be in the patient's record. When the

EDIT? prompt appears, NOHIMS is asking if the information that you have just entered should replace the information in the record. If you have indicated that free text entries are to be made, NOHIMS will then respond with the appropriate prompt after a Y for Yes is entered in response to the EDIT? prompt.

Because we did not include the Major and Presumptive status codes or an asterisk for free text in the last entry, respond N for No to the EDIT? prompt and then enter the data correctly.

EDIT? N
NO CHANGE

>>> MP/401*
 FLBG8 ESSENTIAL HYPERTENSION
SEE PHYSICAL FINDINGS - FOLLOW UP
EDIT? Y
STATUS: MAJOR PRESUMPTIVE
FILE, EDIT, OR IGNORE TEXT > F

>>>

Now the entry for this code is correct. The next changes on the list for Jason Pilot add an item that was omitted and correct one item.

>>> A/HXB-O*
 MBAP2-O HEART EXAMINATION WAS ABNORMAL (OTHER HEART)
STATUS: ABNORMAL
1> MITRAL VALVE REPLACED, 1977
2>

>>> EYX-N
 HBAJ9-N EYES EXAMINATION WAS NORMAL
OLD VALUE: HBAJ9-N EYES EXAMINATION WAS NORMAL
 ARCUS SENILIS
EDIT? Y
STATUS: NORMAL

>>>

As shown in the last correction, the omission of a free text comment in the edit entry will in effect delete the original free text entry from the patient's record. This completes the corrections for Jason P. Pilot. Press RETURN at the triple caret prompt and Y for Yes at the EDITING COMPLETE? prompt to indicate that you are finished editing this encounter. You may continue to edit encounters by entering the next patient's identifying information and encounter date.

>>>

EDITING COMPLETE? Y

EDIT ENCOUNTER FOR PATIENT > RI,C;F;

1 RIGGER,CYNTHIA T

7/7/46

397-20-1465

P

Is this the patient? <Y>

DATE OF ENCOUNTER > 11/26 (11/26/84)

1. DATE: 11/26/84

PROVIDER: SALK,JONAS,MD

SITE: A NORTH ISLAND

TYPE: F PERIODIC EXAM

VISIT CLASSIFICATION: 1 CIVILIAN SCHEDULED PHYSICAL EXAM

2. DATE: 11/26/84

PROVIDER: SALK,JONAS,MD

SITE: A NORTH ISLAND

TYPE: S ASBESTOS SURVEILLANCE

VISIT CLASSIFICATION: 8 PERIODIC ASBESTOS SURVEILLANCE EXAM

EDIT WHICH ENCOUNTER ? > 1

What happened here? There are two encounters entered with the same date in the patient's record. While this may not happen often, it does occur. The items we must edit relate to a Periodic Exam, so we selected the first encounter shown above for editing.

For this encounter, changes are to be made to the Header data; so respond Y for Yes to the EDIT HEADER INFORMATION? prompt. Corrections to Header information are made according to the standard NOHIMS conventions. If the information displayed within carets is correct, you simply null through to the next item. Corrections are made by entering the proper information. The example entries to edit the Header information for Cynthia Rigger follow. We will add a second provider and change the visit classification.

EDIT HEADER INFORMATION? Y

DATE OF ENCOUNTER <11/26/84>

PROVIDER 1 <SALK,JONAS,MD>

PROVIDER 2 > NIGHTINGALE,FLORENCE,RN; OCCUPATIONAL HEALTH NURSE

PROVIDER 3 >

SITE <A NORTH ISLAND >

TYPE <1 PERIODIC EXAM >

VISIT CLASSIFICATION <1 CIVILIAN SCHEDULED PHYSICAL EXAM>

3 CIVILIAN UNSCHEDULED PHYSICAL EXAM

(Continued)

PATIENT: RIGGER,CYNTHIA T
DATE OF ENCOUNTER: 11/26/84
PROVIDERS: SALK,JONAS,MD
NIGHTINGALE,FLORENCE,RN

SITE: NORTH ISLAND
TYPE: PERIODIC EXAM

VISIT CLASSIFICATION: 3 CIVILIAN UNSCHEDULED PHYSICAL EXAM
FILE, EDIT, OR IGNORE? > <

>>>

The first medical item to be edited in Cynthia Rigger's encounter is Urinalysis. You must enter an asterisk after the code in order to change any of the results.

>>> UA*
WNBQ1 URINALYSIS
OLD VALUE: WNBQ1 URINALYSIS

STRAW,
CLR,
SG 1.008,
PH 6.8,
NO UROBIL,
NEG PROT,
NEG GLUC,
NO KET,
NO BLD,
NO BILE,
NO WBCCELLS,
NO RBCCELLS,
NO EPITH,
NO BACT,
NO CRYST,
NEG NITR,
O MUCUS

EDIT Y

COLOR > STRAW
APPEARANCE > CLEAR
SPECIFIC GRAVITY > 1.035
UROBILINOGEN > NEGATIVE
OCCULT BLOOD > NEGATIVE
BILE > NEGATIVE
KETONES > NEGATIVE
GLUCOSE > NEGATIVE
PROTEIN > 1+
PH > 6.8
WHITE BLOOD CELLS > 0
RED BLOOD CELLS > 0

(Continued)

EPITHELIAL CELLS > 0
BACTERIA > NONE
CRYSTALS > NONE
MUCUS > NONE
NITRITE > NEGATIVE

OTHER RESULTS > <ABNORMAL>
1>

>>>

As with other edit entries, all results need to be entered with the edit entry. You cannot simply null through the prompts until the items to be changed appear. Now let us make the remaining changes to Cynthia Rigger's encounter.

>>> JC-E
BBAK1-E PHYSICAL EXAM IS FOR JOB CERTIFICATION (FOR CRANE OR
CONSTRUCTION OPERATOR OR RIGGER)
OLD VALUE: BBAK1-F PHYSICAL EXAM IS FOR JOB CERTIFICATION (FOR EXPLOSIVE
ANDL ER)
EDIT? Y
STATUS: NORMAL

>>> UXX
SQAk1 UPPER EXTREMITIES XRAY

>>> AACQ1-D DISPOSITION LIFTING OR PUSHING OR PULLING OR CARRYING
D. LIFTING OR PUSHING OR PULLING OR CARRYING
1>

>>> CYN
BBJB4 HAZARD SURV CYANIDES
STATUS: NORMAL

>>> E/HSO
BBDP6 HAZARD SURV OTHER HAZARDOUS AGENT
OLD VALUE: BBDP6 HAZARD SURV OTHER HAZARDOUS AGENT
CYANIDE
EDIT? Y
*** BBDP6 FLAGGED AS ERROR ***

Remember, the
Error status code
E is used to
delete items from
the record.

>>>
EDITING COMPLETE? Y
EDIT ENCOUNTER FOR PATIENT >

This concludes our examples of MEDICAL EDIT. At the EDIT ENCOUNTER FOR PATIENT prompt, you can either enter another patient's identifying information or null through the prompt to select another option. If you have been following along on a terminal, you may wish to select the DISPLAY MEDICAL DATA option at the SYSTEM OPTION prompt and review the encounters to see that the changes were indeed made.

SHORT CUTS TO MEDICAL DATA ENTRY AND EDIT

After you become proficient with the data entry and editing procedures described in the preceding subsections, you may wish to try using a short-cut entry mode. The short-cut mode can be used for any medical or work item except Medications. The short-cut mode enables you to enter all of the secondary data (that is, both structured data, such as findings and results, and free text) concurrently with the code.

When the short-cut entry mode is used, you do not receive informational prompts from NOHIMS for the secondary data items to be entered. Because the secondary data to be entered involve several different types of structured data, it is important that you are very familiar with the data entry requirements for a code before you try to use the short-cut entry mode.

In the standard entry mode, an asterisk is entered at the end of the code to indicate that secondary data entry will follow. In the short-cut entry mode, the asterisk is replaced by a semicolon (;) and you continue with the various components of the secondary data before pressing RETURN. Each element of the secondary data is separated by a semicolon. If you have registered patients using the short-cut method of identification, you are already familiar with this technique.

Because the only secondary data for Diagnoses and Problems is free text, the short-cut data entry procedure is easy to use for this type of code. A standard entry for hypertension would appear as follows.

```
>>> PM/401*  
      FLBG8 ESSENTIAL HYPERTENSION  
STATUS: PRESUMPTIVE MAJOR  
1> SEE PHYSICAL FINDINGS  
2>
```

>>>

The short-cut entry for this same example is as follows.

```
>>> PM/401;SEE PHYSICAL FINDINGS  
      FLBG8 ESSENTIAL HYPERTENSION  
STATUS: PRESUMPTIVE MAJOR  
1> SEE PHYSICAL FINDINGS
```

>>>

In the previous example, all of the data were entered on one line, and NOHIMS responded with the information for our confirmation. Notice, however,

that when this mode of entry is used, NOHIMS assumes that we have completed the entry and does not prompt for additional free text lines even though the maximum number of lines have not been entered.

When an entry contains only one element of structured data and no free text, the short-cut mode is equally easy. The standard entry for the Physical Finding, temperature, is the following.

```
>>> TMP  
      CACV1 TEMPERATURE  
ENTER TEMPERATURE > 98.6
```

>>>

The short-cut entry for this same item is the following. The semicolon tells NOHIMS that secondary data follow.

```
>>> TMP;98.6  
      CACV1 TEMPERATURE  
TEMPERATURE: 98.6
```

>>>

The short-cut entry mode also can be used when the secondary data consist of both structured data and free text. The standard mode for entering a Physical Finding with a free text comment is as follows.

```
>>> RR*  
      CAFL1 RESPIRATORY RATE  
ENTER RESPIRATORY RATE > 18  
1> VERY RAPID SHALLOW BREATHING  
2>
```

>>>

The short-cut entry for this same item is the following.

```
>>> RR;18;VERY RAPID SHALLOW BREATHING  
      CAFL1 RESPIRATORY RATE  
RESPIRATORY RATE: 18  
1> VERY RAPID SHALLOW BREATHING
```

>>>

When the short-cut entry mode is used for respiratory rate, the preset format for the secondary data must be followed, and each component of the secondary data is separated by a semicolon. The first item to follow the code must be a value for the respiratory rate (structured data). Subsequent items may be one or two lines of free text. When you know the preset format for the secondary data, the short-cut entry mode will make the data entry process go much faster. Notice that the free text entered in the short-cut entry mode is echoed back on one line.

Examples follow showing the standard and short-cut entries for a blood pressure, another Physical Finding with a result(s).

```
>>> BP  
      CAEFl BLOOD PRESSURE
```

```
BLOOD PRESSURE > 120/60  
MODIFIER >  
BLOOD PRESSURE >  
  <NORMAL>  
STATUS:    NORMAL
```

```
>>> BP;120/60  
      CAEFl BLOOD PRESSURE  
BLOOD PRESSURE: 120/60  
  <NORMAL>  
STATUS:    NORMAL
```

```
>>>
```

Sometimes, however, you may wish to enter more than one blood pressure and/or indicate from which arm the pressure(s) was taken. The full format for entry of structured data for blood pressure is the following.

STATUS/CODE(OR NAME);VALUE;MODIFIER;VALUE;MODIFIER;VALUE;MODIFIER;TEXT;TEXT

Thus, a total number of three different blood pressure readings with modifiers plus two lines of free text can be recorded in each patient's encounter. Knowing the special preset format for a particular item allows us to use the short-cut entry mode. The following are examples of the entry of two blood pressures, one from the right arm and one from the left arm, first using the standard entry mode and then using the short-cut method.

>>> BP
CAEF1 BLOOD PRESSURE

BLOOD PRESSURE > 180/90
MODIFIER > A RIGHT ARM
BLOOD PRESSURE > 170/70
MODIFIER > B LEFT ARM
BLOOD PRESSURE >
<ABNORMAL>
STATUS: ABNORMAL

>>>

The short-cut entry for this same item is as follows.

>>> BP;180/90;A;170/70;B
CAEF1 BLOOD PRESSURE
BLOOD PRESSURE: 180/90 RIGHT ARM
BLOOD PRESSURE: 170/70 LEFT ARM
<ABNORMAL>
STATUS: ABNORMAL

>>>

Sometimes you may wish to enter two blood pressures, without modifiers. Try using the short-cut method to enter just two blood pressures.

>>> BP;120/70;130/70
CAEF1 BLOOD PRESSURE
BLOOD PRESSURE: 120/70 MODIFIER 1 ?
<NORMAL>
STATUS: NORMAL

>>>

What happened here? We forgot to put two semicolons after the first blood pressure. The preset format for blood pressure shows that NOHIMS expects a modifier after each blood pressure. We need to put two semicolons after the first blood pressure to give the effect of nulling through the modifier prompt and to keep NOHIMS from trying to treat the first digit of the second blood pressure as a modifier. Notice that you do not need to put anything after the last item to be entered, even if NOHIMS would accept more items. The correct entry for two blood pressures without modifiers would be as follows. We enter two semicolons to tell NOHIMS that we do not want to enter a modifier, but more information is coming.

>>> BP;120/70;;130/70
CAEF1 BLOOD PRESSURE
BLOOD PRESSURE: 120/70
BLOOD PRESSURE: 130/70
<NORMAL>
STATUS: NORMAL

>>>

The Asbestos Surveillance form has several codes for which the short-cut method can be used. The standard entry of code AWF, Age When First Exposed to Asbestos, which is a History item, is shown below.

>>> AWF
LLER9 AGE WHEN FIRST EXPOSED TO ASBESTOS
STATUS: HEALTH REVIEW
1> 18
2>

>>>

The short-cut entry would appear as follows.

>>> AWF;18
LLER9 AGE WHEN FIRST EXPOSED TO ASBESTOS
STATUS: HEALTH REVIEW
1> 18

>>>

We already use the short-cut method of entry for the Spirometry results on the Asbestos Surveillance form. Recall that we wished to enter both the Laboratory Test and the result at encounter entry. If we were to enter just the code for the test, NOHIMS would file only the lab test with a status of ORDERED in the patient's record. However, when we enter a semicolon and the result after the code, that tells NOHIMS that we want to file a result also. Thus, the entry of the test FEV1 and its result during encounter entry is as follows.

>>> FEV1;3.15
WQGE5 FEV1
RESULTS: 3.15

>>>

Another short-cut method for entering a Laboratory Test and results while working in encounter entry is to add an asterisk after the code. This will tell NOHIMS to prompt for free text, but will also cause NOHIMS to prompt for results. This is useful if you have results for the test at the time you are entering the lab test, as in the case of PFTO, Pulmonary Fxn Test Other Than Asbestos. The short-cut entry for PFTO and results is shown below.

```
>>> PFTO*  
      WQAZ2 PULMONARY FXN TEST OTHER THAN ASBESTOS
```

```
FORCED EXPIRATORY VOLUME IN 1 SECOND FEV1 > 3.82  
FEV1 PERCENT > 89  
FORCED VITAL CAPACITY FVC > 4.15  
FVC PERCENT > 96  
FEV1/FVC > .92  
PHYSICIAN EVALUATION > NORMAL
```

```
OTHER RESULTS > <NORMAL>  
1>
```

```
>>>
```

If you do not have any comments to enter, simply press RETURN to null through the 1> prompt. NOHIMS will file both the test and the results into the patient's record.

We have now illustrated short-cut data entry for Diagnoses and Problems, Physical Findings, History, and Laboratory Tests. When you become knowledgeable regarding the exact format of the secondary data entry requirements for each code, the short-cut entry can speed up the data entry process. BE CAREFUL, HOWEVER, BECAUSE THE SHORT CUT MAY NOT ALWAYS BE THE FASTEST METHOD. This may be particularly true for complicated items such as blood pressure. When an entry has several secondary data entry components, you may be more prone to make mistakes while typing in each entry on a single line. Remember also that the short-cut mode cannot be used for Medications.

SECTION 5. DISPLAY MEDICAL DATA

The medical information about patients that has been stored in the NOHIMS database can be retrieved in a variety of ways. The DISPLAY MEDICAL DATA option is used primarily to access medical information for one patient at a time. For example, a physician or nurse may want to review select information before a scheduled patient is seen. This option allows some or all of the patient's medical record data to either be viewed on a CRT terminal or be printed. This option does not permit any new entries or changes to be made to the patient's medical record. If you need to prepare a report with different content or format than the types of reports found in DISPLAY MEDICAL DATA, the COSTAR Report Generator can be used to develop special reports. Refer to SECTION 7. REPORT GENERATOR for instructions in how to develop special reports.

SECURITY

Because a patient's medical record is confidential information, the authority to access the medical data may be restricted to a limited number of persons within an Occupational Health Unit. The ability to access medical data may also be restricted to certain terminals. If you try to use this option, be certain that you are authorized to do so and that you are working at a terminal that is not restricted from displaying medical data.

SUMMARY OF OPTIONS AVAILABLE FOR DISPLAYING A PATIENT'S MEDICAL DATA

Below is a brief summary description of each of the nine options available in NOHIMS for displaying some or all of a patient's medical data.

LIST ENCOUNTERS

If you do not know the date of a patient encounter that you wish to view, use this option to obtain a list of all encounters for that patient. The list will display the date of each encounter, the site and type of the encounter, and the provider(s), thus providing you with enough information to determine which encounter or encounters you wish to view in complete detail.

ENCOUNTER REPORT

The Encounter Report includes all data about a specific patient visit. If you display all Encounter Reports for a patient, you will see this patient's complete medical record.

MOST RECENT ENCOUNTER

This option presents a display of the complete encounter data for the last (most recent) patient visit or several Encounter Reports in reverse chronological order.

PATIENT SUMMARY

This option summarizes the medical record for a patient in a user-defined format. The preferred format was established in consultation with care providers but can be revised if certain changes are desired. A Data Matrix can be defined as part of the Patient Summary which distinguishes it from an alternative summary of the medical record called the Status Report.

STATUS REPORT

The Status Report summarizes the medical record for a patient in a predefined format that cannot be changed without major reprogramming. The Status Report serves as a directory for the total content of a patient's medical record and as a summary of the patient's medical status.

INDEX PATIENT

This option displays an index to all of the sections of a patient's medical record, providing a quick review of the main features of the record. After viewing the indexed list, you may request a detailed listing of any or all sections, or an interactive flowchart based on the information you have seen in the index.

FLOWCHART

Flowcharts present selected medical information across the horizontal axis of a display with corresponding dates of entry into the medical record displayed on the vertical axis. Flowcharts are used, for example, to trace the occurrence of abnormal lab results, to follow the effect of a medication, or to track a disease process over time.

INTERACTIVE FLOWCHART

This option allows you to create your own flowcharts for a particular patient. Creating an interactive flowchart provides the quickest way to track the occurrence of a problem; a physical exam finding; prescribed therapies, procedures, and medications; and the results of lab tests.

REGISTRATION DATA CHECK

This option provides a display of a patient's registration data without having to leave the DISPLAY MEDICAL DATA option and return to the REGISTRATION module. The display is exactly the same as the Patient Display in DISPLAY REGISTRATION.

Each of the DISPLAY MEDICAL DATA options in NOHIMS is described and explained in more detail in the following pages.

LIST ENCOUNTERS/ENCOUNTER REPORT/MOST RECENT ENCOUNTER

Select the DISPLAY MEDICAL DATA option at the SYSTEM OPTION prompt as shown below.

SYSTEM OPTION > DISPLAY MEDICAL DATA
NAME OR UNIT # >

The first prompt of this option asks you to identify the patient for whom medical information is to be displayed. You enter the patient's name or unit number before you select the type of information to be displayed. This feature allows you to review several displays for the same patient without having to re-enter the patient's identifying data. (Note: If you want paper copies of several displays, you may wish to select the desired displays from a printing terminal or use the PRINT MEDICAL DATA option described in SECTION 6 of this manual.) Let's display medical data for James Greeley.

NAME OR UNIT # > GR,J;M;

1 GREELEY,JAMES C M 7/14/50 061-32-7684 P

Is this the patient? <Y>

NOHIMS finds a patient that matches the characters we have entered in response to the NAME OR UNIT # prompt and then asks us, Is this the patient? The default response is Yes. If we are satisfied that this is the patient whose medical data we want to display, we simply press RETURN. NOHIMS then responds with the DISPLAY MEDICAL DATA OPTION prompt. To see what the options are, enter a question mark at this prompt.

DISPLAY MEDICAL DATA OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

- LIST ENCOUNTERS
- ENCOUNTER REPORT
- MOST RECENT ENCOUNTER
- PATIENT SUMMARY
- STATUS REPORT
- INDEX PATIENT
- FLOWCHART
- INTERACTIVE FLOWCHART
- REGISTRATION DATA CHECK

DISPLAY MEDICAL DATA OPTION >

The first three options on this list work together as will be seen. If you do not know the date of an encounter for a patient that you wish to display, use the LIST ENCOUNTERS option to obtain a list of all encounters for that patient. The list is produced in reverse chronological order with the most recent encounter displaying first.

DISPLAY MEDICAL DATA OPTION > LIST ENCOUNTERS

ENCOUNTER LIST UN: 061-32-7684 PRINTED: 8/25/85

- 1) 7/26/85 SITE NORTH ISLAND TYPE ASBESTOS SURVEILLANCE REED,WALTER,MD
- 2) 7/26/85 SITE NORTH ISLAND TYPE PERIODIC EXAM REED,WALTER,MD
 NIGHTINGALE,FLORENCE,RN
- 3) 12/16/84 SITE NORTH ISLAND TYPE PERIODIC EXAM SALK, JONAS,MD
 NIGHTINGALE,FLORENCE,RN
- 4) 10/1/84 SITE NORTH ISLAND TYPE OTHER REPEAT TEST REED,WALTER,MD
- 5) 9/26/84 SITE NORTH ISLAND TYPE ASBESTOS SURVEILLANCE REED,WALTER,MD
- 6) 9/26/84 SITE NORTH ISLAND TYPE PERIODIC EXAM REED,WALTER,MD
 NIGHTINGALE,FLORENCE,RN

DISPLAY MEDICAL DATA OPTION >

Let's suppose that we want to display the encounter data for the Periodic Exam given to James Greeley on 9/26/84.

DISPLAY MEDICAL DATA OPTION > ENCOUNTER REPORT

DATE >

If somehow we forgot the date of the desired encounter, we could enter an ^L at the DATE prompt to request a list of James Greeley's encounters. The list displayed would be exactly the same as the list that was obtained using the LIST ENCOUNTERS option. However, at the end of the list, NOHIMS would prompt for WHICH ENCOUNTER? allowing you to select the number of the encounter you wish displayed at this point. Let's assume that we did not forget the date, so we enter 9/26/84 at the DATE prompt.

DATE > 9/26/84

- 1) 9/26/84 SITE NORTH ISLAND TYPE ASBESTOS SURVEILLANCE REED, WALTER,MD
- 2) 9/26/84 SITE NORTH ISLAND TYPE PERIODIC EXAM REED,WALTER,MD
 NIGHTINGALE,FLORENCE,RN

WHICH ENCOUNTER? 2

There were two encounters on 9/26/84 for James Greeley. NOHIMS asked us which encounter we wanted to display and we entered 2 to select the Periodic Exam. The complete Encounter Report for this Periodic Exam is shown next. Note that any abnormal findings or results are flagged with an asterisk. If you are working at a CRT terminal, the Encounter Report will appear a little at a time. Whenever your screen is full, NOHIMS will give you a HOLD, CONTINUE OR QUIT <C> prompt. If you press RETURN, you will be able to continue viewing the ENCOUNTER REPORT until the display is completed.

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ENCOUNTER REPORT UN: 061-32-7684 PRINTED: 8/24/85
GREELEY, JAMES C (M) 35 YRS (7/14/50)

9/26/84 SITE NORTH ISLAND TYPE PERIODIC EXAM
CIVILIAN SCHEDULED PHYSICAL EXAM REED, WALTER, MD
NIGHTINGALE, FLORENCE, RN

DISPOSITIONS

AACQ1 DISPOSITION FULL WORK OR DUTY

DIAGNOSES/PROBLEMS

FLBG8 ESSENTIAL HYPERTENSION [H/O]
MLBX5 OTHER FORMS CHRONIC ISCHEMIC HEART DISEASE [H/O]
CORONARY DISEASE
JLAQ9 HEARING LOSS
HIGH FREQ. SLIGHT
NLCX4 HEMORRHOIDS [INACTIVE]
1979

PHYSICAL EXAM

BBAK1-G PHYSICAL EXAM IS FOR JOB CERTIFICATION (FOR AIRCRAFT HANDLER)

BBAQ5 HAZARD SURV ASBESTOS
BBAN8 HAZARD SURV MERCURY Inorganic
BBBF3 HAZARD SURV NOISE

BFAY1-F FULL PHYSICIAN EXAMINATION

CAJC1	HEIGHT	69
CAKH1	WEIGHT	215
CACV1	TEMPERATURE	98.4
CADA1	PULSE	78
CAFL1	RESPIRATORY RATE	18
CAEF1 *	BLOOD PRESSURE	150/92

CBAM1-N GENERAL APPEARANCE WAS NORMAL
OBESITY

GBAW1-N SKIN EXAMINATION WAS NORMAL

HBAJ9-N EYES EXAMINATION WAS NORMAL
ARCUS SENILIS

JBAY4-TO * EAR EXAMINATION WAS ABNORMAL (TYMPANI) (OTHER EARS)
TYMPANI-RIGHT. SCAR FROM RUPTURED EARDRUM. OTHER-SLIGHT
HEARING LOSS.

JBAH2-N NOSE EXAMINATION WAS NORMAL

JBAQ3-N ORAL CAVITY EXAMINATION WAS NORMAL

VBAX1-N NECK EXAMINATION WAS NORMAL

LBAE1-N THORAX AND LUNGS EXAMINATION WAS NORMAL

MBAP2-M * HEART EXAMINATION WAS ABNORMAL (MURMUR OR MURMURS)

PBAT2-N AXILLAE EXAMINATION WAS NORMAL

QBAN1-N ABDOMEN EXAMINATION WAS NORMAL

SBAS1-N MALE GENITALS EXAMINATION WAS NORMAL

QBAW2-R RECTAL EXAMINATION WAS REFUSED

VBAE2-N BACK EXAMINATION WAS NORMAL

VBAM3-N EXTREMITIES AND JOINTS EXAMINATION WAS NORMAL

WBAZ1-N NEUROPSYCHIATRIC EXAMINATION WAS NORMAL

NBAJ1-N VASCULAR SYSTEM EXAMINATION WAS NORMAL

CBAV2 OTHER FINDINGS
PHYSICALLY FIT FOR CONTINUED EMPLOYMENT.

TESTS

CNAF2	INORGANIC PHOSPHATE P	2.8
CNBD1 *	SODIUM Na	300
CNBL2	POTASSIUM K	4.2
CNBT3	CHLORIDES SERUM Cl	105
CN8G8	CARBON DIOXIDE SERUM CO2	30
CNCZ3	BLOOD UREA NITROGEN Bun	17
CNCP5	CREATININE BLOOD Cr	1.1
CNEC2	GLUCOSE SERUM FASTING Glucose	106
CNFA1	CALCIUM Ca	8.7
CNKX1	BILIRUBIN TOTAL Tb	0.6
CNKE2	BILIRUBIN DIRECT Db	0.1
CNPT1	URIC ACID BLOOD Ua	5.9
CPCM1	CHOLESTEROL BLOOD Chol	209
CPCS5	TRIGLYCERIDES Trig	73

ENBH1	SERUM GLUTAMIC OXALOACETIC TRANSAMINASE Sgot	18
ENBN5	SERUM GLUTAMIC PYRUVIC TRANSAMINASE Alt	24
ENGA3	LDH ISOENZYMES Ld	161
ENHF3	CREATINE PHOSPHOKINASE ISOENZYMES Ck	100
ENPF2	FRACTIONATED ALKALINE PHOSPHATASE Alp	98
EPBL1	TOTAL SERUM PROTEINS Tp	6.4
EPCR1	ALBUMIN Alb	4.2
MNA22	COMPLETE BLOOD COUNT [DON'T DISPLAY ENTRY]	
MNAQ4	RBC MORPHOLOGY	WNL
MNAY5	PLATELETS	ADQ
MNBY1	HEMOGLOBIN	16.8
MNBN3	HEMATOCRIT	48.
MNBW4	MEAN CORPUSCULAR VOLUME	87
MNBD5	RED BLOOD CELL COUNT	5.62
MNDJ1	WHITE BLOOD CELL COUNT	7.7
MNDZ3	DIFFERENTIAL COUNT	
	EOSINOPHILS > 4	
	LYMPHOCYTES > 37	
	NEUTROPHILS SEGS > 57	
	NEUTROBANDS > 21	
	100 CELLS COUNTED	
SNAD1	CHEST XRAY ASBESTOS	NL WNBQ1
URINALYSIS	STRAW, CLR, SG 1.021, PH 6.5, NO UROBIL, NEG PROT, NEG GLUC, NO KET, NO BLD, NO BILE, NO WBCCELLS, NO RBCCELLS, NO EPITH, NO BACT, NO CRYST, NEG NITR, 0 MUCUS	
WQFT1	PULMONARY FXN TEST ASBESTOS	FEV1 3.84, FEV1% 87, VC 4.13, VC% 93, FEV1/VC .93, MD EVAL NORMAL,
WRDR5	DIFFERENTIAL WITH MORPHOLOGY !DON'T DISPLAY ENTRY!	
WRFV4	SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY [DON'T DISPLAY ENTRY]	
WRGK2	AUDIOGRAM FOR EXCESSIVE NOISE EXPOSURE [ORDERED]	
	ADMINISTRATIVE	
ARAB4	FORM CONTROL NUMBER	193
ASAC7	JOB TITLE	A/C ENGINE MECHANIC
ASBM1	WORK SUPERVISOR	SMITH, MARK
ASBK4	BUILDING NUMBER	32415
ASAK8	SHOP NUMBER	95222
ASBC3	SHOP TELEPHONE NUMBER	437-4821
DATE >		

The ENCOUNTER REPORT is the most complete display of medical record data for an individual patient visit. It includes data collected at the time of the encounter as well as any data entered at subsequent times such as lab results or edited information. The format for the ENCOUNTER REPORT follows the standard divisions of the NOHIMS medical record. These sections are the following:

1. Header (which includes patient identifying data, encounter information, and name(s) of care provider)
2. Dispositions
3. Diagnoses/Problems
4. Physical Exam
5. Medications and Therapies
6. Procedures
7. Tests
8. Administrative

The first section of the ENCOUNTER REPORT is the HEADER which contains identifying information about the patient, the date of the display or printout, and information about the encounter including the provider(s). The DISPOSITIONS section is next and contains the disposition(s) selected by the physician. Notice that NOHIMS displayed the internal code to the left of the disposition. The DIAGNOSES/PROBLEMS section displays the medical assessment entered by the physician for the encounter. Statuses assigned to the codes by the care provider are also displayed. Short duration is indicated by the right caret symbol (>) appearing between the internal code and the problem name. If no caret appears, it is assumed that the condition is of long duration. Other statuses, such as History Of or Rule Out, are displayed in abbreviated form in brackets after the diagnosis/problem. When comments have been entered for an item, they are displayed after the item. Currently, Medical History data collected at periodic examinations are not entered into NOHIMS. When these data are implemented, they will also appear in this section with [REVIEW] after the item. Asbestos Surveillance encounters have medical history items which display in this section.

The PHYSICAL EXAM section contains the types of surveillances conducted and the physical findings. TESTS contains all laboratory tests, audiograms, radiologies, and pulmonary function tests ordered during the encounter with their results. The last section, ADMINISTRATIVE, contains work information and the Form Control Number.

If no data have been entered into one of the sections of the ENCOUNTER REPORT, this section will not appear in the display. At the end of the display, the DATE prompt appears again, allowing you to specify the date of another encounter that you may wish to see for this same patient. You may null through the DATE prompt to return to the DISPLAY MEDICAL DATA OPTION prompt.

If you are only interested in viewing the encounter for the last time the patient was seen, you would use the MOST RECENT ENCOUNTER option as follows.

DISPLAY MEDICAL DATA OPTION > MOST RECENT ENCOUNTER

7/26/85 SITE NORTH ISLAND TYPE ASBESTOS SURVEILLANCE REED, WALTER, MD
OK? Y

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ENCOUNTER REPORT UN: 061-32-7684 PRINTED: 8/24/85
GREELEY, JAMES C (M) 35 YRS (7/14/50)

7/26/85 SITE NORTH ISLAND TYPE ASBESTOS SURVEILLANCE
PERIODIC ASBESTOS SURVEILLANCE EXAM REED, WALTER, MD

DIAGNOSES/PROBLEMS

LLET6-Y CURRENTLY WORKS DIRECTLY WITH ASBESTOS (YES) [REVIEW]
LLEB7-Y ASBESTOS EXPOSURE WAS IS ON REGULAR BASIS (YES) [REVIEW]

LLEJ8-B YEARS OF ASBESTOS EXPOSURE (MORE THAN 1 AND LESS THAN 5) [REVIEW]
LLER9 AGE WHEN FIRST EXPOSED TO ASBESTOS [REVIEW]
22
LLFL1-N COUGH HAVE OR USUALLY HAVE (NO) [REVIEW]
LLFT2-N PHLEGM HAVE OR USUALLY HAVE (NO) [REVIEW]
LLFB3-N WHEEZING HAVE OR USUALLY HAVE (NO) [REVIEW]

LLFJ4-Y SHORTNESS OF BREATH HAVE OR USUALLY HAVE (YES) [REVIEW]

LLFR5-Y HAS SMOKED CIGARETTES (YES) [REVIEW]
LLFZ6 AGE BEGUN SMOKING CIGARETTES [REVIEW]
15
LLFG7-B AVERAGE NO OF PACKS OF CIGARETTES SMOKED (ONE PACK PER DAY)
[REVIEW]
LLFX9-N SMOKES PIPE OR CIGARS (NO) [REVIEW]
LLGZ2-N HAD SERIOUS LUNG DISEASE REQUIRING HOSPITALIZATION (NO) [REVIEW]

PHYSICAL EXAM

CAKH1 WEIGHT 215
CAJC1 HEIGHT 69
LBAV3-O APPEARANCE STATURE (OBESE)

LBAC4-N APPEARANCE CHEST CONFIGURATION (NORMAL)

LBAK5-N APPEARANCE CLUBBING (NONE)

LBAS6-O CRACKLES (LOCALIZED EARLY INSPIRATORY)

LBAA7-N WHEEZES (NONE)

TESTS

WQAP4 SPIROMETRY FVC OBSERVED IN LITERS 3.42
WQAE6 SPIROMETRY FEV1 OBSERVED IN LITERS 3.15

7/26/85 SITE NORTH ISLAND TYPE PERIODIC EXAM REED, WALTER, MD
NIGHTINGALE, FLORENCE, RN

OK? ^

DISPLAY MEDICAL DATA OPTION >

When NOHIMS has finished displaying the MOST RECENT ENCOUNTER (in the same format as the ENCOUNTER REPORT), it then displays encounter information for the next most recent encounter working backwards chronologically and asks if it is OK to display the corresponding Encounter Report. Since we want to move on to look at other displays of patient medical data, we used the ^ command to return to the DISPLAY MEDICAL DATA OPTION prompt.

PATIENT SUMMARY/STATUS REPORT

The purpose of the PATIENT SUMMARY option is to summarize the medical record for a patient across encounters (as the STATUS REPORT does also). However, the Patient Summary report is presented in a user-defined format. On a division-by-division basis, a choice can be made to display data from all visits made by the patient; or a cutoff can be established, for example, only displaying lab tests from the three previous visits or three previous months. The preferred format for displaying Patient Summary reports was established in consultation with Navy care providers but can be revised by the System Manager if certain changes are desired. However, there can be only one user-defined format at any given time. Each provider cannot have his or her own format for the Patient Summary report.

In addition to the standard divisions of the patient's medical record, the PATIENT SUMMARY also includes a Data Matrix feature that displays data corresponding to selected NOHIMS codes for the most recent 'N' encounters, where 'N' is the number of encounter dates that will fit across the top of the display. A different data matrix code list can be specified for male and female patients, and for different age groups. There is no limit to the number of age breakdowns, nor is there a limit to the number of codes selected to be displayed for either sex or age group. The codes selected must be unmodified, however, and any occurrence of that code, whether modified or not, will be displayed. The range of normal values for a particular test may be included in the data matrix display as well. Currently, there are nine codes in the Data Matrix and the same list is used for every patient.

The format for the division display, the code selection criteria, and the contents of the Data Matrix can all be altered by your System Manager. The changes can only be made if the modifications are desired by a consensus of the care providers using the system.

The Patient Summary report consists of a number of sections. You may display or print any one or any combination of the sections as shown next.

DISPLAY MEDICAL DATA OPTION > PATIENT SUMMARY
SECTIONS> ?
ENTER A LIST OF SECTION MNEMONICS, SEPARATED BY COMMAS,
IN THE DESIRED ORDER OF OUTPUT:

HD HEADER
AL ALLERGIES
HX MEDICAL HISTORY
DX DIAGNOSES
MED MEDICATIONS
OCC OCCUPATIONAL HISTORY
PE PHYSICAL EXAM
PR PROCEDURES
TX TESTS
DIS DISPOSITIONS
EX EXPOSURE DATA
DM DATA MATRIX
ALL FOR THE STANDARD LIST

Note that Allergies and Occupational History appear in the list of sections. Currently in NOHIMS, allergy items appear under Medical History. As of the writing of this manual, the Occupational History Data were not being entered into the system. In any case, these data do not lend themselves to the PATIENT SUMMARY format. Therefore, do not select these two options. Let's look at an entire PATIENT SUMMARY for James Greeley.

SECTIONS> ALL

The first section of the PATIENT SUMMARY is always the HEADER which contains identifying information about the patient and the date of the display or printout. The remaining sections are separated by section headings.

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PATIENT SUMMARY

UN:061-32-7684

PRINTED: 8/24/85

GREELEY, JAMES C (M) 35 YRS (7/14/50)

Notify in Emergency: NONE

Phone Number in Emergency: NONE

Duty Station or Activity: NAVAL AIR REWORK FACILITY

Primary Clinic: 1 NORTH ISLAND

Ethnic Background: 9 OTHER

Job Title: A/C ENGINE MECHANIC

Shop Number: 95222

Work Supervisor: SMITH, MARK

Shop Telephone: 437-4821

The MEDICAL HISTORY section appears next. When a History item has been recorded at more than one encounter, the display contains the date the History item was first noted, followed by the number of times the item appears in the medical record, and then the last date that the item was recorded. If the code has a modifier or free text associated with it, only the latest entry, if any, will be displayed. The care provider is the one who last noted the History item.

***** MEDICAL HISTORY *****

9/26/84-2-7/26/85	CURRENTLY WORKS DIRECTLY WITH ASBESTOS	REED,W
	(YES)	
9/26/84-2-7/26/85	ASBESTOS EXPOSURE WAS IS ON REGULAR	REED,W
	BASIS (YES)	
9/26/84-2-7/26/85	YEARS OF ASBESTOS EXPOSURE (MORE THAN 1	REED,W
	AND LESS THAN 5)	
9/26/84-2-7/26/85	AGE WHEN FIRST EXPOSED TO ASBESTOS	REED,W
	22	
9/26/84-2-7/26/85	COUGH HAVE OR USUALLY HAVE (NO)	REED,W
9/26/84-2-7/26/85	PHLEGM HAVE OR USUALLY HAVE (NO)	REED,W
9/26/84-2-7/26/85	WHEEZING HAVE OR USUALLY HAVE (NO)	REED,W
9/26/84-2-7/26/85	SHORTNESS OF BREATH HAVE OR USUALLY HAVE	REED,W
	(YES)	
9/26/84-2-7/26/85	HAS SMOKED CIGARETTES (YES)	REED,W
9/26/84-2-7/26/85	AGE BEGUN SMOKING CIGARETTES	REED,W
	15	
9/26/84-2-7/26/85	AVERAGE NO OF PACKS OF CIGARETTES SMOKED	REED,W
	(ONE PACK PER DAY)	
9/26/84-2-7/26/85	SMOKES PIPE OR CIGARS (NO)	REED,W
9/26/84-2-7/26/85	HAD SERIOUS LUNG DISEASE REQUIRING	REED,W
	HOSPITALIZATION (NO)	

The PROBLEMS AND DIAGNOSES section presents a list of all patient problems, both major and minor. The display format includes the date (in the same format as for MEDICAL HISTORY) and name of the care provider who most recently made the entry in the patient's medical record. The information in brackets following the problem or diagnosis indicates a status code when present. Any free text comments that appear correspond to the most recent encounter.

***** PROBLEMS AND DIAGNOSES *****

MINOR

9/26/84-2-7/26/85	HEARING LOSS	REED,W
	HIGH FREQ. SLIGHT	
9/26/84-3-7/26/85	ESSENTIAL HYPERTENSION [H/O]	REED,W
9/26/84-2-7/26/85	OTHER FORMS CHRONIC ISCHEMIC HEART	REED,W
	DISEASE [H/O]	
	CORONARY DISEASE	
9/26/84-2-7/26/85	HEMORRHOIDS [INACT]	REED,W
	1979	

The PHYSICAL EXAMINATION DATA AND FINDINGS section includes all surveillances and physical findings. The date is displayed in the same manner as for MEDICAL HISTORY. An asterisk indicates that the code has an abnormal status. The most recent results, if any, are displayed after the item; the text, if any, from the most recent encounter is displayed on the line below the item. The care provider is the most recent one who noted the finding in the medical record.

***** PHYSICAL EXAMINATION DATA AND FINDINGS *****

9/26/84-3-7/26/85	FULL PHYSICIAN EXAMINATION	REED,W
9/26/84-5-7/26/85	HEIGHT 69	REED,W
9/26/84-5-7/26/85	WEIGHT 215	REED,W
9/26/84-3-7/26/85	TEMPERATURE 98.4	REED,W
9/26/84-3-7/26/85	PULSE 78	REED,W
9/26/84-3-7/26/85	RESPIRATORY RATE 18	REED,W
9/26/84-3-7/26/85	* BLOOD PRESSURE 150/92	REED,W
9/26/84-2-7/26/85	PHYSICAL EXAM IS FOR JOB CERTIFICATION (FOR AIRCRAFT HANDLER)	REED,W
9/26/84-3-7/26/85	HAZARD SURV ASBESTOS	REED,W
9/26/84-2-7/26/85	HAZARD SURV MERCURY Inorganic	REED,W
9/26/84-2-7/26/85	HAZARD SURV NOISE	REED,W
9/26/84-2-7/26/85	APPEARANCE STATURE (OBESE)	REED,W
9/26/84-2-7/26/85	APPEARANCE CHEST CONFIGURATION (NORMAL)	REED,W
9/26/84-2-7/26/85	APPEARANCE CLUBBING (NONE)	REED,W
9/26/84-2-7/26/85	CRACKLES (LOCALIZED EARLY INSPIRATORY)	REED,W
9/26/84-2-7/26/85	WHEEZES (NONE)	REED,W
9/26/84-3-7/26/85	GENERAL APPEARANCE WAS NORMAL	REED,W
	OBESEITY	
9/26/84-2-7/26/85	SKIN EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	EYES EXAMINATION WAS NORMAL	REED,W
	ARCUS SENILIS	
9/26/84-2-7/26/85	* EAR EXAMINATION WAS ABNORMAL (TYMPANI) (OTHER EARS)	REED,W
	TYMPANI-RIGHT. SCAR FROM RUPTURED EARDRUM.	
	OTHER-SLIGHT HEARING LOSS.	
9/26/84-2-7/26/85	NOSE EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	ORAL CAVITY EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	NECK EXAMINATION WAS NORMAL	REED,W
9/26/84-3-7/26/85	THORAX AND LUNGS EXAMINATION WAS NORMAL	REED,W
9/26/84-3-7/26/85	* HEART EXAMINATION WAS ABNORMAL (MURMUR OR MURMURS)	REED,W
9/26/84-2-7/26/85	AXILLAE EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	ABDOMEN EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	MALE GENITALS EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	RECTAL EXAMINATION WAS REFUSED	REED,W
9/26/84-3-7/26/85	BACK EXAMINATION WAS NORMAL	REED,W
9/26/84-3-7/26/85	EXTREMITIES AND JOINTS EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	NEUROPSYCHIATRIC EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	VASCULAR SYSTEM EXAMINATION WAS NORMAL	REED,W
9/26/84-2-7/26/85	OTHER FINDINGS	REED,W
	PHYSICALLY FIT FOR CONTINUED EMPLOYMENT.	
12/16/84	HAZARD SURV LEAD Inorganic	SALK,J

The PROCEDURES section follows PHYSICAL EXAMINATION DATA AND FINDINGS. The date in the usual format, name of the procedure, care provider, and most recent free text comments, if any, are given for each procedure performed. If no procedures were done, this section does not display. James Greeley did not have any procedures, so the next section in his PATIENT SUMMARY is the LABORATORY TESTS section.

The LABORATORY TESTS are grouped into categories such as CHEMISTRY, HEMATOLOGY, MICROBIOLOGY, RADIOLOGY, and MISCELLANEOUS. The date is displayed in the same format as previously described. The abnormal flag, if any, and test name are displayed next with the normal range of values for a test result shown in brackets after the name. Any status codes are also shown in brackets after the name. If results have been entered in the patient record, they are displayed after the name. Free text comments, if any, appear on the line below. Tests having abnormal results are displayed first within each category of lab tests. The abnormal flag appears if there has ever been an abnormal result, although only the most recent test result is displayed.

***** LABORATORY TESTS *****

CHEMISTRY

9/26/84-3-12/16/84	*	SODIUM Na [136-145]	145
9/26/84		POTASSIUM K [3.5-5.3]	4.2
9/26/84		CHLORIDES SERUM Cl [97-109]	105
9/26/84		CARBON DIOXIDE SERUM CO2 [24-30]	30
9/26/84		CREATININE BLOOD Cr [.4-1.5]	1.1
9/26/84		BLOOD UREA NITROGEN Bun [7-26]	17
9/26/84		URIC ACID BLOOD Ua [3.9-9]	5.9
9/26/84		CALCIUM Ca [8.5-10.5]	8.7
9/26/84		INORGANIC PHOSPHATE P [2.5-4.9]	2.8
9/26/84		BILIRUBIN TOTAL Tb [.2-1.2]	0.6
9/26/84		BILIRUBIN DIRECT Db [0-.5]	0.1
9/26/84		TOTAL SERUM PROTEINS Tp [6-8.5]	6.4
9/26/84		ALBUMIN Alb [3-5.5]	4.2
9/26/84		FRACTIONATED ALKALINE PHOSPHATASE Alp [30-115]	98
9/26/84		SERUM GLUTAMIC PYRUVIC TRANSAMINASE Alt [0-45]	24
9/26/84		SERUM GLUTAMIC OXALOACETIC TRANSAMINASE Sgot [0-41]	18
9/26/84		LDH ISOENZYMES Ld [60-200]	161
9/26/84		CREATINE PHOSPHOKINASE ISOENZYMES Ck [0-225]	100
9/26/84		TRIGLYCERIDES Trig [40-160]	73
9/26/84		GLUCOSE SERUM FASTING Glucose [70-115]	106
9/26/84		CHOLESTEROL BLOOD Chol [140-250]	209
12/16/84		BLOOD LEAD INORGANIC [0-19.9]	[ORD]

HEMATOLOGY

9/26/84		RED BLOOD CELL COUNT [4.6-6.2]	5.62
9/26/84		HEMOGLOBIN [14-18]	16.8
9/26/84		HEMATOCRIT [42-52]	48.8
9/26/84		MEAN CORPUSCULAR VOLUME [80-99]	87

9/26/84 WHITE BLOOD CELL COUNT [4.8-10.8] 7.7

DIFFERENTIAL COUNT

EOSINOPHILS > 4

LYMPHOCYTES > 37

NEUTROPHILS SEGS > 57

NEUTROBANDS > 2

100 CELLS COUNTED 12/16/84-2-9/26/84

12/16/84-2-9/26/84

PLATELETS ADQ

12/16/84-2-9/26/84

RBC MORPHOLOGY WNL

9/26/84-3-7/26/85

COMPLETE BLOOD COUNT [ORD]

RADIOLOGY

9/26/84-2-7/26/85

CHEST XRAY ASBESTOS [ORD]

MISCELLANEOUS

9/26/84-3-8/24/85

SPIROMETRY FVC OBSERVED IN LITERS 3.26

9/26/84-3-8/24/85

SPIROMETRY FEV1 OBSERVED IN LITERS 3.01

9/26/84-2-7/26/85

SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY
[ORD]

9/26/84-3-7/26/85

URINALYSIS [ORD]

9/26/84-3-7/26/85

DIFFERENTIAL WITH MORPHOLOGY [ORD]

9/26/84-2-7/26/85

PULMONARY FXN TEST ASBESTOS [ORD]

9/26/84-2-7/26/85

AUDIOGRAM FOR EXCESSIVE NOISE EXPOSURE [ORD]

The LABORATORY TESTS section is followed by the MEDICATIONS section. The date that the medication was prescribed is displayed first. Then the name is displayed, with any available prescription information such as dose, frequency, quantity, and refills, along with the care provider who wrote the prescription. If no medications were prescribed, this section does not display or print, as is the case in our example of James Greeley's PATIENT SUMMARY.

The next section to be displayed is DISPOSITIONS. This section includes care plans and/or restrictions for the patient as they were noted on the Encounter Form. Also displayed are the date of the encounter and the care provider's name.

***** DISPOSITIONS *****

7/26/85

FULL WORK OR DUTY

REED,W

12/16/84

REFER CIVILIAN FACILITY ANOTHER DAY

SALK,J

OTHER

PMD RE BLOOD PRESSURE INCREASE

The DATA MATRIX section is the last section of the PATIENT SUMMARY. The last four encounter dates for James Greeley are displayed across the top of the Data Matrix. (The 9/26/84 column summarizes the results from both encounters on that date.) The TODAY column is for the care provider's use in making notes for comparison to other findings. In this example, nine NOHIMS codes are listed in the left-hand column of the Data Matrix. Normal ranges, if any, are displayed within brackets. The cells or boxes of the matrix contain entries corresponding to entries in the patient's medical record for that particular date. Entries of *ABN* for blood pressure on 9/26/84, 12/16/84, and 7/26/85 flag an abnormal result. If a test was ordered but results have not been entered yet, an entry of ORDERED will appear in the box. If the long name for a code does not fit in the first column, NOHIMS substitutes the code on the Encounter Form that is used to enter the item. CPL is the entry code for Chest Xray PA and Lateral.

***** DATA MATRIX *****

	! 9/26/84 !	10/1/84 !	12/16/84 !	7/26/85 !	TODAY !
BLOOD PRESSURE	! 150/92 !	! !	! 165/95 !	! 150/92 !	! !
	! *ABN* !	! !	! *ABN* !	! *ABN* !	! !
PULSE	! 78 !	! !	! 76 !	! 78 !	! !
	! !	! !	! 6 !	! !	! !
WEIGHT	! 215 !	! !	! 206 !	! 215 !	! !
	! !	! !	! !	! !	! !
EKG	! !	! !	! !	! !	! !
	! !	! !	! !	! !	! !
CPL	! !	! !	! !	! !	! !
	! !	! !	! !	! !	! !
HEMOGLOBIN	! 16.8 !	! !	! !	! !	! !
[14-18]	! !	! !	! !	! !	! !
HEMATOCRIT	! 48.8 !	! !	! !	! !	! !
[42-52]	! !	! !	! !	! !	! !
RBC	! 5.62 !	! !	! !	! !	! !
[4.6-6.2]	! !	! !	! !	! !	! !
WBC	! 7.7 !	! !	! !	! !	! !
[4.8-10.8]	! !	! !	! !	! !	! !

SECTIONS>

When the display of the DATA MATRIX section is completed, NOHIMS returns with the SECTIONS prompt. Because we have reviewed the complete PATIENT SUMMARY for James Greeley, we will use the ^ command or null through the SECTIONS prompt to return to the DISPLAY MEDICAL DATA OPTION prompt.

The STATUS REPORT is an alternative option for displaying a summary of the patient's medical record. You may enter an S for STATUS at the DISPLAY MEDICAL DATA OPTION prompt to see what a Status Report looks like. However, it is strongly recommended that you always select to display the PATIENT SUMMARY in preference to the STATUS REPORT because the PATIENT SUMMARY has been customized to display all sections of the patient's medical record along with a matrix of selected medical data and it also includes NOHIMS Industrial Exposure Data. Neither the Data Matrix nor Industrial Exposure Data is part of a STATUS REPORT display.

The Diagnoses/Problems section of the STATUS REPORT may contain up to four subsections: Health Review (same as Medical History in the PATIENT SUMMARY), Allergies (currently not used in NOHIMS), Problems with a Major status, and Problems with a Minor status. If data from a subsection are not recorded for the patient, that subsection will not display. The data contents for the Diagnoses/Problems section are similar to those in the PATIENT SUMMARY. If the free text displayed is not from the latest encounter, the date of entry is shown in brackets after the text.

The Physical Exam section of the STATUS REPORT contains the most recent physical findings. Contents are similar to the PATIENT SUMMARY. The Therapies section contains Occupational History data which should be disregarded. This section also contains MEDICATIONS. The Procedures section lists all procedures entered for the patient.

In the Tests section of the STATUS REPORT, if a test has been performed several times and there were no abnormal results, only the latest test is included in the STATUS REPORT. If there has ever been an abnormal result for a test, the test is flagged with an asterisk and the five most recent test results entered are displayed.

INDEX PATIENT

The INDEX PATIENT option provides an index to all of the sections of a patient's medical record. As with PATIENT SUMMARY, you can request any one or any combination of sections to be displayed. NOHIMS responds with a list of all items in the medical record for the division(s) selected along with results, abnormal flags, and modifiers, if any. If an item has a code for data entry, that code is displayed. If the item does not have a code, the full name is displayed instead. At various points in the display of most sections, NOHIMS allows you to request a detailed listing or an interactive flowchart based on the data you have seen in the index. To select the INDEX PATIENT option, enter IND for INDEX PATIENT (to differentiate it from INTERACTIVE FLOWCHART) at the DISPLAY MEDICAL DATA OPTION prompt as follows.

DISPLAY MEDICAL DATA OPTION > INDEX PATIENT

SECTION > ?

AVAILABLE SECTIONS ARE:

H-HEADER

DIS-DISPOSITIONS

DX-DIAGNOSES/PROBLEMS

PE-PHYSICAL EXAM

RX-THERAPIES (Medications and Nonmedication Therapies)

PR-PROCEDURES

TX-TEST RESULTS (Laboratory)

A-ALL OF THE ABOVE

ANY COMBINATION OF THE ABOVE SECTIONS WILL BE DISPLAYED
IF SEPARATED BY SEMICOLONS

SECTION >

We entered a ? at the SECTION prompt and NOHIMS displayed the list of sections that can be selected. Again, Therapies may contain Occupational History Data which should be disregarded. Medications will also be listed under Therapies. Let's start by looking at only one section of the index to James Greeley's medical record, namely, his test results.

SECTION > TX
TESTS

INORGANIC PHOSPHATE P (9/26/84) 2.8
* SODIUM Na (12/16/84) 145
POTASSIUM K (9/26/84) 4.2
CHLORIDES SERUM Cl (9/26/84) 105
CARBON DIOXIDE SERUM CO2 (9/26/84) 30
BLOOD UREA NITROGEN Bun (9/26/84) 17
CREATININE BLOOD Cr (9/26/84) 1.1
GLUCOSE SERUM FASTING Glucose (9/26/84) 106
CALCIUM Ca (9/26/84) 8.7
BILIRUBIN TOTAL Tb (9/26/84) 0.6
BILIRUBIN DIRECT Db (9/26/84) 0.1
URIC ACID BLOOD Ua (9/26/84) 5.9
CHOLESTEROL BLOOD Chol (9/26/84) 209
TRIGLYCERIDES Trig (9/26/84) 73
SERUM GLUTAMIC OXALOACETIC TRANSAMINASE Sgot (9/26/84) 18
SERUM GLUTAMIC PYRUVIC TRANSAMINASE Alt (9/26/84) 24
LDH ISOENZYMES Ld (9/26/84) 161
CREATINE PHOSPHOKINASE ISOENZYMES Ck (9/26/84) 100
FRACTIONATED ALKALINE PHOSPHATASE Alp (9/26/84) 98

HOLD, CONTINUE, QUIT, DETAIL, OR FLOWCHART >

(We nulled through this
prompt to continue to the
end of the TESTS index.)

ENBH1	SERUM GLUTAMIC OXALOACETIC TRANSAMINASE Sgot	9/26/84	18
ENBN5	SERUM GLUTAMIC PYRUVIC TRANSAMINASE Alt	9/26/84	24
ENGA3	LDH ISOENZYMES Ld	9/26/84	161
ENHF3	CREATINE PHOSPHOKINASE ISOENZYMES Ck	9/26/84	100
ENPF2	FRACTIONATED ALKALINE PHOSPHATASE Alp	9/26/84	98
EPBL1	TOTAL SERUM PROTEINS Tp	9/26/84	6.4
EPCR1	ALBUMIN Alb	9/26/84	4.2
HNLN1	BLOOD LEAD INORGANIC [ORDERED]	12/16/84	
	HEMATOLOGY		
MNA22	COMPLETE BLOOD COUNT [ORDERED]	7/26/85	
MNAQ4	RBC MORPHOLOGY	9/26/84	WNL
MNAY5	PLATELETS	9/26/84	ADQ
MNBY1	HEMOGLOBIN	9/26/84	16.8
MNBN3	HEMATOCRIT	9/26/84	48.8
MNBW4	MEAN CORPUSCULAR VOLUME	9/26/84	87
MNBD5	RED BLOOD CELL COUNT	9/26/84	5.62
MNDJ1	WHITE BLOOD CELL COUNT	9/26/84	7.7
MNDZ3	DIFFERENTIAL COUNT	9/26/84	DIFFERENTIAL COUNT
	EOSINOPHILS > 4		
	LYMPHOCYTES > 37		
	NEUTROPHILS SEGS > 57		
	NEUTROBANDS > 2		
	100 CELLS COUNTED		
RADIOLOGY			
SNAD1	CHEST XRAY ASBESTOS [ORDERED]	7/26/85	
MISCELLANEOUS			
WNBQ1	URINALYSIS [ORDERED]	7/26/85	
WQAP4	SPIROMETRY FVC OBSERVED IN LITERS	8/24/85	3.26
WQAE6	SPIROMETRY FEV1 OBSERVED IN LITERS	8/24/85	3.01
WQFT1	PULMONARY FXN TEST ASBESTOS [ORDERED]	7/26/85	
WRDR5	DIFFERENTIAL WITH MORPHOLOGY [ORDERED]	7/26/85	
WRFV4	SMAC FOR LIVER KIDNEY AND OR BLOOD CHEMISTRY [ORDERED]	7/26/85	
WRGK2	AUDIOGRAM FOR EXCESSIVE NOISE EXPOSURE [ORDERED]	7/26/85	

SECTION >

When we asked to see the detail for James Greeley's lab tests, we were provided with a display broken down by type of test---CHEMISTRY, HEMATOLOGY, RADIOLOGY, and MISCELLANEOUS tests. Because the index to the TESTS section was so long, NOHIMS gave several opportunities to request more Detail or a Flowchart. The index displays the most recent test date and result. The detailed listing provides the date and result for every test performed.

You can also choose to flowchart some of these tests for this patient at the HOLD, CONTINUE, QUIT, DETAIL, OR FLOWCHART prompt, depending on what we found to be of interest in the detailed display. We can flowchart up to eight NOHIMS codes in exactly the same way that an INTERACTIVE FLOWCHART can be constructed---another display option that is explained shortly. If you wanted to see an index to other sections of James Greeley's medical record, you would enter those sections at the SECTION prompt.

FLOWCHART

A flowchart is a matrix display of data corresponding to selected NOHIMS codes and dates. Abbreviated names of the codes appear across the horizontal axis of the report with their corresponding dates of entry into the medical record displayed on the vertical axis. The cells or boxes within the matrix of a flowchart display the actual data entered for selected codes in the patient's medical record including any results and/or associated textual comments. If the results are abnormal, they are flagged with an asterisk. The following flowcharts have been defined for NOHIMS. Other flowcharts can be added as required.

DISPLAY MEDICAL DATA OPTION > FLOWCHART

FLOWCHART FORMAT> ^L

- 1 HYPERTENSION
- 2 DIABETES
- 3 RED BLOOD COUNT
- 4 CONGESTIVE HEART FAILURE
- 5 KIDNEY FAILURE
- 6 URINALYSIS
- 7 LIVER FUNCTION TESTS

FLOWCHART FORMAT>

Let's look at three of these flowcharts for James Greeley---the ones for HYPERTENSION, URINALYSIS, and LIVER FUNCTION TESTS. Notice that abnormal findings are flagged with an asterisk. You may display any of the other flowcharts if you are interested in seeing what they look like.

FLOWCHART FORMAT> 1 HYPERTENSION

GREELEY, JAMES C UNIT NUMBER: 061-32-7684
 DATE ! WGT! BLOOD ! BUN ! CREA! URIC! K+ ! MEDICATIONS
 ! ! PRESSURE ! ! ! ACID! !

 9/26/84 ! 215! *150/92 ! ! 1.1 ! 5.9 ! 4.2 !

9/26/84 ! 215! ! ! ! !

12/16/84! 206! *165/95 ! ! ! !

7/26/85 ! 215! ! ! ! !

7/26/85 ! 215! *150/92 ! ! ! !

FLOWCHART FORMAT> 6 URINALYSIS

GREELEY, JAMES C UNIT NUMBER: 061-32-7684
 DATE ! URINALYSIS RESULTS

 9/26/84 ! STRAW, CLR, SG 1.021, PH 6.5, NO UROBIL, NEG PROT, NEG GLUC,
 ! NO KET, NO BLD, NO BILE, NO WBCCELLS, NO RBCCELLS, NO EPITH,
 ! NO BACT, NO CRY, NEG NITR, 0 MUCUS

12/16/84! STRAW, CLR, SG 1.025, PH 7.0, NO UROBIL, NEG PROT, NEG GLUC,
 ! NO KET, NO BLD, NO BILE, NO WBCCELLS, NO RBCCELLS, NO EPITH,
 ! RARE BACT, NO CRY, NEG NITR, 0 MUCUS

7/26/85 ! [ORD]

FLOWCHART FORMAT> 7 LIVER FUNCTION TESTS

GREELEY, JAMES C UNIT NUMBER: 061-32-7684
 DATE ! SGOT ! SGPT ! BILI ! ALK ! HB ! WT
 ! ! ! ! PHOS ! !

 9/26/84 ! 18 ! 24 ! 0.6 ! ! 16.8 ! 215

9/26/84 ! ! ! ! ! ! 215

12/16/84! ! ! ! ! ! 206

7/26/85 ! ! ! ! ! ! 215

7/26/85 ! ! ! ! ! ! 215

All of the flowcharts in NOHIMS were set up so that they could be easily selected through the FLOWCHART option. However, there is another display option in NOHIMS that allows you to create your own flowchart for a particular patient. This option is called INTERACTIVE FLOWCHART and is explained next.

INTERACTIVE FLOWCHART

If you are interested in flowcharting a different set of selected medical data information than the NOHIMS codes included in the standard flowcharts, you have the option of creating a special flowchart for a particular patient by defining for NOHIMS the codes that you want to include in the display. But remember that NOHIMS does not permanently store the codes that you specify for an INTERACTIVE FLOWCHART. Consequently, if you want to produce the same flowchart later for the same or a different patient, you will have to re-enter all of the codes. Since this is an interactive process, that is why this option is called INTERACTIVE FLOWCHART. If you find that you are re-creating the same flowchart over and over again, ask your System Manager to set it up as a standard choice in the FLOWCHART display option.

NOHIMS allows you to specify up to eight codes for creating an INTERACTIVE FLOWCHART. This flowchart displays patient data in a similar format to the standard flowcharts but in reverse chronological order. You may enter the NOHIMS internal code (such as CA(V1), the code for data entry (such as TMP), or the full name (such as TEMPERATURE). You will find the data entry codes on the data collection forms, or you can check with your System Manager for the internal codes. Enter INT at the DISPLAY MEDICAL DATA OPTION prompt to select the INTERACTIVE FLOWCHART option.

DISPLAY MEDICAL DATA OPTION > INTERACTIVE FLOWCHART

SPECIFY UP TO 8 CODES TO FLOWCHART

CODE #1> CAEF1 BLOOD PRESSURE
CODE #2>

After you enter the first code, NOHIMS then prompts for the second code and will continue prompting as long as you keep entering codes. If you enter more than eight codes, when you null through the last CODE # prompt to indicate that you have no more codes to enter, NOHIMS will give you the message TOO MANY CODES -- PLEASE SHORTEN THE LIST. Then the codes you have entered will be displayed one by one. You may retain a code by nulling through. To delete a code, enter a minus sign (-).

When you have entered all of the codes you wish to display in flowchart format, null through the next CODE # prompt. This tells NOHIMS that there are no more codes and to construct the flowchart. Your tailor-made flowchart

for the patient you have identified will display in reverse chronological order all of the occurrences of the codes you have specified, along with any free text comments, prescription information, and test results. Any abnormal results will be flagged with an asterisk. The example INTERACTIVE FLOWCHART for James Greeley that we began to create by entering the internal code for BLOOD PRESSURE at the CODE #1 prompt is completed as shown below.

```
CODE #2> CNBD1  SODIUM Na
CODE #3> FLBG8  ESSENTIAL HYPERTENSION
CODE #4>
```

DATE	! BLOOD PRESSURE	! SODIUM Na	! ESSENTIAL ! HYPERTENSION
12/16/84	! * 165/95	! 145	! X2 YRS. BLOOD ! PRESSURE UP FROM ! LAST EXAM ! [HX]
10/1/84	!	! 140	!
9/26/84	! * 150/92	! * 300	! [HX]

DISPLAY MEDICAL DATA OPTION >

When NOHIMS has completed the INTERACTIVE FLOWCHART display, it returns with the DISPLAY MEDICAL DATA OPTION prompt rather than a prompt for another INTERACTIVE FLOWCHART since it does not store the codes you have specified. If you want to produce a variation on this flowchart or create a different flowchart for this patient, you have to select the INTERACTIVE FLOWCHART option again. Let's create another flowchart for James Greeley relating to ASBESTOS.

DISPLAY MEDICAL DATA OPTION > INTERACTIVE FLOWCHART

SPECIFY UP TO 8 CODES TO FLOWCHART

```
CODE #1> BBAQ5  HAZARD SURV ASBESTOS
CODE #2> LLET6  CURRENTLY WORKS DIRECTLY WITH ASBESTOS  (CWA is the data
                                                             entry code.)
CODE #3> CHEST XRAY ASBESTOS
          SNAD1  CHEST XRAY ASBESTOS
CODE #4> WQFT1  PULMONARY FXN TEST ASBESTOS
CODE #5>
```

DATE	HAZARD SURV ASBESTOS	CWA	CHEST XRAY ASBESTOS	PULMONARY FXN TEST ASBESTOS
7/26/85	[NOTED]		[ORD]	[ORD]
7/26/85		(YES) [MINOR]		
12/16/84	[NOTED]			
9/26/84		(YES) [MINOR]		
9/26/84	[NOTED]		NL	FEV1 3.84, FEV1% 87, VC 4.13, VC% 93, FEV1/VC .93 MD EVAL NORMAL,

DISPLAY MEDICAL DATA OPTION >

Beware that the more codes you specify to create an INTERACTIVE FLOWCHART, the narrower the column width available for each code. If there are lengthy free text comments, it will take many lines to display the entire flowchart.

INTERACTIVE FLOWCHART provides the quickest way to track the occurrence of a problem; a physical exam finding; prescribed therapies, procedures, and medications; and the results of lab tests. If, for example, you wanted to quickly track blood pressure for James Greeley, you could use the INTERACTIVE FLOWCHART option as shown next. The asterisk flags a result as ABNORMAL.

DISPLAY MEDICAL DATA OPTION > INTERACTIVE FLOWCHART

SPECIFY UP TO 8 CODES TO FLOWCHART

CODE #1> BP

- 1) BP
- 2) BPM

(PHYS) CAEF1
(DIAG) CLDD7

ITEM # > 1

CAEF1 BLOOD PRESSURE
CODE #2>

DATE ! BLOOD PRESSURE

=====

7/26/85 ! * 150/92

12/16/84! * 165/95

9/26/84 ! * 150/90

DISPLAY MEDICAL DATA OPTION >

REGISTRATION DATA CHECK

REGISTRATION DATA CHECK allows you to display the registration data for a particular patient. This option can be very convenient if you wish to verify a Registration data item while you are displaying medical data since you do not need to leave the DISPLAY MEDICAL DATA option to do this. As with other DISPLAY MEDICAL DATA options, you cannot edit the data, only display it. The use of this option is shown below.

DISPLAY MEDICAL DATA OPTION > REGISTRATION DATA CHECK

..... PATIENT DISPLAY.....

GREELEY,JAMES C (M) 7/14/50

DATE OF REGISTRATION: 9/26/84

SSN: 061-32-7684

DUTY STATION OR ACTIVITY . . . 1 NAVAL AIR REWORK FACILITY

PRIMARY CLINIC 1 NORTH ISLAND

ETHNIC BACKGROUND. 9 OTHER

DISPLAY MEDICAL DATA OPTION >

Notice that NOHIMS automatically returns you to the DISPLAY MEDICAL DATA OPTION prompt after the Registration data are displayed. You then may select another option.

MOVING ON TO ANOTHER PATIENT

We now have completed a review of all of the standard and user-defined NOHIMS reports available in the DISPLAY MEDICAL DATA option for one patient. Recall that we only needed to enter the patient's name once at the very beginning. If we want to review medical data for another patient, simply enter the ^ command or null through in response to the DISPLAY MEDICAL DATA OPTION prompt. NOHIMS then will display the NAME OR UNIT # prompt. You would enter the new patient's identifying information and go on to display the patient's medical data. Nulling through the NAME OR UNIT # prompt will return you to the SYSTEM OPTION prompt and allow you to select another system option.

DISPLAY MEDICAL DATA OPTION > ^ (or RETURN to null through)
NAME OR UNIT # >

SYSTEM OPTION >

SECTION 6.

PRINT MEDICAL DATA

When it is necessary to have the standard or user-defined COSTAR medical reports printed on paper rather than displayed at a terminal, the PRINT MEDICAL DATA primary system option is used. If you are authorized to have medical data printed, the following subsections describe the three PRINT OPTION prompt, select PRINT MEDICAL DATA. Then, enter a ? in response to the PRINT MEDICAL DATA OPTION prompt to review the available print options.

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

DAILY ENCOUNTER REPORTS
HALT DAILY ER PRINTER
SPECIAL PRINT

Daily Encounter Reports

The DAILY ENCOUNTER REPORTS option produces a set of Encounter Reports that were input on a single day. Customarily, the reports will be run at the end of the day, after all batches have been closed. The option also can be used to produce all Encounter Reports and a Status Report for the same set of patients. The set of patients are those whom encounters were entered on the specified day. The printing of Encounter Reports can be interrupted and restarted.

The order of the printed records is determined by your Systems Manager. The order may be (1) by patient's last name alphabetically, (2) by order of input, (3) by unit number, (4) by order of last two digits of the unit number.

The PRINT MEDICAL DATA option can be used to produce copies of Encounter Reports that were entered during the most recent five days. To have an Encounter Report printed that was entered more than five day previously, the SPECIAL PRINT option is used.

The following is a description of three ways to use the DAILY ENCOUNTER REPORTS print option.

1. How To Produce Only Reports of Encounters Entered on the Current Date or Another Date Up to Five Days Previously

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > D A I L Y E N C O U N T E R R E P O R T S

PRINT ENCOUNTERS FOR <MM/DD/YY>

The current
date is
displayed.

Return - Nulling through specifies that only reports entered on the current date are to be printed.

Date - Enter another date up to five days previously in MM/DD/YY format or in any of the abbreviated forms recognized by COSTAR.

OUTPUT TYPE <E> RETURN

RETURN - Nulling though specifies Encounter Report only.

DEVICE > RETURN

DEVICE # - Enter the device number of the printer to be used for printing the output. If you do not know the number, you may enter ^L to list the devices and their locations.

RETURN - Nulling through assumes THIS DEVICE, that is, the terminal at which you are working. If you are not working at a printing terminal, COSTAR will advise you that the DEVICE SELECTED MUST BE A HARD-COPY TERMINAL.

THIS DEVICE? >Y
STARTED

If different device has been specified, COSTAR would have displayed a message that the print run had been started and that this terminal was FREE to do other tasks. The BREAK key must then be used to re-initialize the terminal at which you are working.

When the Encounter Reports have finished printing, the following message will appear on the printing device.

ENCOUNTERS FOR MM/DD/YY HAVE FINISHED PRINTING
NN ENCOUNTERS INPUT ON MM/DD/YY

NN stands
for number of
encounters.

PRINT MEDICAL DATA OPTION >

2. How To Restart the Current Day's Encounter Reports Print Run or an
Encounter Reports Print Run for Another Date up to Five Days
Previously

If a print run is interrupted by a computer or program problem, or if the reports are not usable because of a printer problem, it may be necessary to restart the current day's (or specified day's) print run.

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > DAILY ENCOUNTER REPORTS
PRINT ENCOUNTERS FOR <MM/DD/YY>

COSTAR assumes the current day's date. Another date up to five days previously may be specified in MM/DD/YY format or in any of the abbreviated recognized by COSTAR.

RESTART OUTPUT TYPE <E>

COSTAR remembers that a print run for Encounter Reports has already been started for the date specified. By responding with the ? command to this prompt, COSTAR describes the various report options.

E - For Encounter Report only.
S - For Status Report only.
A - For all encounters in the patient's record.
SE - For the Status and Encounter Reports.
(examples of other valid combinations are SA, ES, and AS)

RETURN - Nulling through specifies Encounter Report only.

RESTART OUTPUT TYPE <E> RETURN

IDENTIFY LAST CORRECTLY PRINTED REPORT BY NAME OR UNIT #: >0
RESTART FROM BEGINNING

Name or Unit # - Entering the patient name or unit number of the last report that was completed restarts the printing at the point of interruption. If an invalid name or unit number is entered, this prompt will reappear. An invalid name or unit number is one that is not associated with patients for whom reports are being printed.

0 - Entering 0 starts the printing from the beginning.

RETURN - Nulling through restarts the printing from the beginning.

(continued)

DEVICE > 31 JOB 22 STARTED ON DEVICE 31 - TERMINAL FREE

Entering 31 in response to the Device prompt, for example, specifies the line number of a printing terminal. COSTAR responds, for example, JOB 22 STARTED ON DEVICE 31. TERMINAL FREE indicates that the BREAK key must be depressed to use COSTAR again from this device. Nulling through the DEVICE prompt specifies that the printing is to be done from this device.

3. How To Specify Printing of Reports Other Than Encounter Reports Only

SYSTEM OPTION > PRINT MEDICAL DATA

PRINT MEDICAL DATA OPTION > DAILY ENCOUNTER REPORTS

PRINT ENCOUNTERS FOR <MM/DD/YY>

COSTAR assumes the current day's date. Another date up to five days previously may be specified in MM/DD/YY format or in any of the abbreviated forms recognized by COSTAR.

OUTPUT TYPE <E>

E - For Encounter Report only.

S - For Status Report Only.

A - For all encounters in the patient's record.

SE - For the Status and Encounter Reports.

(examples of other valid combinations are SA, ES, and AS)

RETURN - Nulling through specifies Encounter Report only.

Remember that no matter which reports you select, the list of patients from whom the reports are printed consists of those who had encounters entered on the date specified.

OUTPUT TYPE <E> SE

Status and Encounter Reports are to be printed.

DEVICE > 27 - JOB 24 STARTED ON DEVICE 27 - TERMINAL FREE

Entering 27 in response to the DEVICE prompt, for example, specifies the line number of a printing terminal. COSTAR responds, for example, JOB 24 STARTED ON DEVICE 27. TERMINAL FREE indicates that the BREAK key must be depressed to use COSTAR again from this device. Nulling through the DEVICE prompt specifies that the printing is to be done from this device.

Halt Daily ER (Encounter Report) Printer

If the computer must be brought down for some reason, or if a problem develops with the printer such that illegible or unusable reports are being produced, it may become necessary to use HALT DAILY ER PRINTER option. This action must be taken from a device other than the one which the reports are being printed.

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > HALT DAILY ER PRINTER
HALT DEVICE # 74 FOR MM/DD/YY ? Y WILL HALT AFTER RECORD
COMPLETED

COSTAR knows that a print run is printing on Device # 74, for example, for a specified date. When the HALT DAILY ER PRINTER option is selected, COSTAR responds by displaying the device number, the specified date, and requests confirmation to HALT. When you respond Yes (Y), COSTAR advises that the printing device WILL HALT AFTER RECORD COMPLETED.

PRINT MEDICAL DATA OPTION>

To restart the printing of this print run from either the beginning or from the point of interruption, use the restart sequence described as the second procedure under Daily Encounter Reports.

Special Print

The SPECIAL PRINT option allows the user to specify a group of patients for whom standard and/or user-defined medical reports are to be produced. The user can specify whether COSTAR should produce the reports according to the list of names as they were input, alphabetically by patient's last name, in unit number order, or according to the terminal digit of the unit number order. The reports selected to be printed (i.e., Status Report, Most Recent Encounter, all Encounters, Patient Summary, Flowcharts, or any combination thereof) can be specified for each patient individually or for the group of patients as a whole.

Once it is created, the list of names is retained in COSTAR's memory associated with the device on which the list was created. This feature requires the user to use the same device in order to re-input or re-output from the same list. For example, if a user creates a list of names on Device 44 and then prints reports for this list on Device 56, the user must use Device 44 to access the list again. However, the printing can be interrupted from any terminal other than the device on which the reports are printing.

Two aspects of how to use the SPECIAL PRINT option are described below.

1. Creating a Special Print File

SYSTEM OPTION > Print Medical Data

Print Medical Data Option > Special Print

Starting a New File

ORDER <1> ?

ENTER 1 OR NULL FOR INPUT ORDER

T FOR TERMINAL DIGIT OF UNIT NUMBER ORDER

U FOR UNIT NUMBER ORDER

A FOR ALPHABETIC ORDER (PATIENT'S LAST NAME)

^ GOES TO PREVIOUS QUESTION

^Q GETS OUT OF FUNCTION

ORDER <1> INPUT ORDER

SAME TYPE OUTPUT FOR EACH RECORD? <YES>

RETURN

Nulling through is the same as responding YES. Responding NO to this prompt allows you to specify the type of output for each individual name in the file.

(continued)

OUTPUT> ?

ENTER S FOR STATUS REPORT

M FOR MOST RECENT ENCOUNTER

A FOR ALL ENCOUNTERS

P FOR PATIENT SUMMARY

F FOR FLOWCHARTS

OR ANY COMBINATION THEREOF

^ GOES TO PREVIOUS QUESTION

^Q GETS OUT OF FUNCTION

OUTPUT> S

NAME OR UNIT NUMBER > 600012C

ABALONEY,JEAN

F 3/4/33

60012C

A61AP

NAME OR UNIT NUMBER > COWREY, CH

SEX > M

DATE OF BIRTH OR AGE >

RETURN

1 COWREY,CHESTER

M 3/28/33

60079Y

A128A GP

IS THIS THE PATIENT? Y

NAME OR UNIT NUMBER >

RETURN

No more patients are specified for this Special Print run.

SPECIAL PRINT OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

INPUT (ADDITIONAL ENTRIES TO THE FILE OF PATIENTS)

OUTPUT (REPORTS FOR THE CURRENT FILE OF PATIENTS)

LIST (THE CURRENT FILE OF PATIENTS)

DELETE (THE CURRENT FILE OF PATIENTS AND START AFRESH)

HALT (ANOTHER PRINTER)

SPECIAL PRINT OPTION > OUTPUT

DEVICE > 56

RUN THIS JOB NOW? <Y> Y

or RETURN

JOB 4 STARTED ON DEVICE 56 -TERMINAL FREE

Entering 56 in response to the DEVICE prompt, for example, specifies the line number of a printing terminal. After you answer Yes (Y) to the RUN THIS JOB NOW? prompt, COSTAR responds, for example, JOB 4 STARTED ON DEVICE 56. TERMINAL FREE indicates that the BREAK key must be depressed to use COSTAR again from this device. Nulling through the DEVICE prompt specifies that the printing is to be done from this device.

Remember that the list of patients is retained in COSTAR's memory and should be deleted when it is no longer needed.

2. Adding to and Listing the Special File; Halting and Restarting the Print; Deleting the File

If the Special Print File is not deleted after the print run is produced, the file of patient names is retained in COSTAR's memory associated with the device on which the file was created. When that same device accesses the SPECIAL PRINT option, the following prompts are presented.

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > S P E C I A L P R I N T

SPECIAL PRINT OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

INPUT (ADDITIONAL ENTRIES TO THE FILE OF PATIENTS)

OUTPUT (REPORTS FOR THE CURRENT FILE OF PATIENTS)

LIST (THE CURRENT FILE OF PATIENTS)

DELETE (THE CURRENT FILE OF PATIENTS AND START AFRESH)

HALT (ANOTHER PRINTER)

SPECIAL PRINT OPTION > I N P U T

INPUT ORDER

COSTAR assumes that you want the output printed in the order in which the names were input, which is what had been specified previously.

We first will INPUT more names to the file, then LIST the names, then ask for OUTPUT, then HALT the print run; and finally, we will DELETE the file.

SAME TYPE OUTPUT FOR EACH RECORD? <YES> Y

OUTPUT <S> ?

ENTER S FOR STATUS REPORT

M FOR MOST RECENT ENCOUNTER

A FOR ALL ENCOUNTERS

P FOR PATIENT SUMMARY

F FOR FLOWCHARTS

OR ANY COMBINATION THEREOF

OUTPUT S>

RETURN

NAME OR UNIT NUMBER > 60011N

ABALONEY,JOE

M 3/3/33

600011N

A61A GP

If Joe Abaloney's name was already in the file, COSTAR would have responded:

ALREADY IN FILE WITH OUTPUT: S

DELETE ENTRY OR CHANGE OUTPUT>

In this example, Joe Abaloney is a new addition to the file.
(continued)

NAME OR UNIT NUMBER > CHITON,K;;

1 CHITON,KATHARINA F 6/15/05 600083L A130N GP

IS THIS THE PATIENT? Y

We now have added two patients to the file.

NAME OR UNIT NUMBER > RETURN

SPECIAL PRINT OPTION > LIST
INPUT ORDER

ABALONEY,JEAN	UN:600012C	OUTPUT:S
COWREY,CHESTER	UN:600079Y	OUTPUT:S
ABALONEY,JOE	UN:600011N	OUTPUT:S
CHITON,KATHARINA	UN:600083L	OUTPUT:S

SPECIAL PRINT OPTION > OUTPUT

DEVICE > 24

RUN THIS JOB NOW? <Y> Y

or RETURN

JOB 7 STARTED ON DEVICE 24 -TERMINAL FREE

Entering 24 in response to the DEVICE prompt, for example, specifies the line number of a printing terminal. After you answer Yes (Y) to the RUN THIS JOB NOW? prompt, COSTAR responds, for example, JOB 7 STARTED ON DEVICE 24. TERMINAL FREE indicates that the BREAK key must be depressed to use COSTAR again from this device. Nulling through the DEVICE prompt specifies that the printing is to be done from this device. In this case, COSTAR will ask for confirmation as follows:

THIS DEVICE (Y/N) ? > Y
DEVICE #4 STARTED

In the example above, this device is line #4. When the print run is completed, COSTAR will display the following message of Device 4.

DONE

You may need to HALT the Special Print run for some reason. If so, follow this procedure.

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > S P E C I A L P R I N T
SPECIAL PRINT OPTION > H A L T

DEVICE # > 37 WILL HALT AFTER CURRENT RECORD FINISHES
SPECIAL PRINT OPTION >

To restart the Special Print run, use the device on which the list was created and specify OUTPUT again. COSTAR will prompt you to identify the last correctly printed report by name or unit number. Or you could enter zero (0) to restart the run from the beginning.

The list of patients for a Special Print run is retained in COSTAR's memory, and this file should be deleted when it is no longer needed. The file must be deleted using the same device on which the file was created. To DELETE a Special Print File of patients, follow this procedure.

SYSTEM OPTION > P R I N T M E D I C A L D A T A

PRINT MEDICAL DATA OPTION > S P E C I A L P R I N T
SPECIAL PRINT OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

INPUT (ADDITIONAL ENTRIES TO THE FILE OF PATIENTS)

OUTPUT (REPORTS FOR THE CURRENT FILE OF PATIENTS)

LIST (THE CURRENT FILE OF PATIENTS)

DELETE (THE CURRENT FILE OF PATIENTS AND START AFRESH)

HALT (ANOTHER PRINTER)

SPECIAL PRINT OPTION > DELETE

OK TO DELETE FILE? <NO> Y

COSTAR requests confirmation that it really is okay to delete the file.

FILE DELETED

STARTING A NEW FILE

ORDER <1> ^Q

COSTAR assumes you want to create a new file at this point and prompts for the file order. If you do not want to create another file, then use the ^Q command to exit from SPECIAL PRINT and to move on to other COSTAR options.

SECTION 7. REPORT GENERATOR

The NOHIMS user documentation for the Report Generator contains four elements. The first element is a list of Report Generator reports which were designed for NOHIMS and are currently in the system. The second element contains examples of how to run reports that are already created and stored in NOHIMS. The third element is a set of the NOHIMS data collection forms with the NOHIMS internal codes corresponding to each data item written on the forms. This documentation of the codes used by NOHIMS will be useful both in interpreting the database and in the generation of Report Generator reports. The last element is a copy of the public domain version of the COSTAR Report Generator documentation.

REPORT GENERATOR REPORTS

Of the eleven reports created and stored in NOHIMS at the time this documentation was prepared, nine are for the semi-annual Navy-required 6260 report. These nine reports have 6260 at the end of their names. The reports select encounters related to periodic examinations (types A-R, T and U). The other two reports---ASBESTOS and AUDIOLIST---were useful during system development and were left in as examples of other uses for the Report Generator. The following is a list of the reports in NOHIMS with a short description of each one.

ACTIVITY6260	This report tabulates duty station (also called Activity), counting one duty station for each encounter.
CIVMIL6260	This report is a tabulation of visit classification which, in effect, gives a tabulation of civilian and military status.
HAZARD6260	This report is a tabulation of all codes in the Physical Examination division. It provides frequencies of the Hazard Surveillances and Protective Equipment for the 6260 report. It also gives frequencies of normal and abnormal examinations.
JOB6260	This report is a tabulation of the modifiers of code JC, Physical Examination Is for Job Certification. It gives the frequency of examinations for job certification by type of job.

(Continued)

LAB6260

This report tabulates all items in the NOHIMS Laboratory division, including Pulmonary Function Tests, Radiology, and Audiology.

LABTEST6260

This report selects only those encounters in which at least one laboratory test was ordered under the Laboratory Test heading on the Physical Exam Data Sheet (PEDS). Thus, the number of encounters selected is the same as the number of encounters where at least one laboratory test was ordered. The number of encounters selected is not stored with the CRG working tables, so the report should be run on a printer.

RADIOLOGY6260

This report selects only those encounters in which one of the Radiologies on the PEDS or job aid was ordered. Thus, the number of encounters selected is the same as the number of encounters where the patient was exposed. The number of encounters selected is not stored with the CRG working tables, so the report should be run on a printer.

TYPE6260C

This report selects encounters in which the visit classification is either 1 or 3, in effect selecting for civilians, and tabulates the frequency of the types of examination.

TYPE6260M

This report selects encounters in which the visit classification is either 2 or 4, in effect selecting for military, and tabulates the frequency of the types of examination.

ASBESTOS

This report lists the name, date, and social security number of encounters that were entered from the Asbestos Surveillance form (6260/5).

AUDIOLIST

This report lists the name, date, and status of audiograms for all patients who had an audiogram ordered.

RUN/RESTART REPORT

The following instructions for running a report have been excerpted from the public domain documentation for the COSTAR Report Generator to allow a user to quickly and easily run a report already created and stored in NOHIMS. Users who wish to create/edit reports, print working tables, etc. are referred to the public domain COSTAR Report Generator (CRG) Users' Manual.

The RUN feature of the RUN/RESTART REPORT option is used to run a report for which specifications have been saved. When a report is run, a new search of the NOHIMS files is made and new reports are prepared. The LIST report and TAB report will be printed on the device specified in this option. If a TAB report is specified, the tables will also be stored in CRG working storage. Every time a TAB report is run, the new tables replace any that may be stored in working storage, so only the tables from the most recent run will be in the working storage. The RUN feature can be used to (1) run the same report for different periods of time, (2) enter instructions for running a report at a specified time, and/or (3) place the report in a job queue to be run later.

To illustrate these various options, let's say that we wish to first run the report called TYPE6260C on encounters from 7/1/85 through 7/31/85 at 5:30PM on 8/23/85 and, when that report is finished, run the report called ACTIVITY6260 on the same encounters.

COSTAR REPORT GENERATOR OPTION > RUN/RESTART REPORT

**RUN/RESTART REPORT

REPORT NAME >

ENTER THE NAME OF THE REPORT YOU WISH TO RUN OR

ENTER '^L' TO SEE A LIST OF REPORTS IN THE DIRECTORY

REPORT NAME > TYPE6260C - 12/31/84 BLESSING,KATHRYN E

TAB OF TYPE OF EXAMINATION FOR CIVILIANS

First, we selected the RUN/RESTART REPORT option, and then we entered the name of the report we wanted to run at the second REPORT NAME prompt. NOHIMS responded with the date the report was last edited, the name of the creator, and a description of the report.

STARTING DATE > 7/1 (7/1/85)

ENDING DATE > 7/31

The STARTING DATE and ENDING DATE prompts are used to specify the period of time to be covered by the report. If you wish to have the report run on the entire set of encounters, simply press RETURN at the prompts. NOHIMS will assume the current date for the ending date. You may use the T convention at these prompts. We entered 7/1 and 7/31.

DOUBLE SPACE REPORT <N>

Double spacing can be specified for the report. The default response to this prompt is NO, so just press RETURN to accept single spacing.

USE VISIT ORDER INDEX FOR FAST REPORT <N> Y

You may select to use the visit order index for a faster report. If you use the visit order index, NOHIMS will only read the visits that fall within the time period you have specified. If you do not use the visit order index, NOHIMS will search the entire database for visits that match the time criteria specified. Enter Y for Yes to use the visit order index.

RUN ON DEVICE <69> (SYSGEN 69)
RUN THIS JOB NOW <Y> N

The RUN ON DEVICE prompt tells the system which terminal or printer should be used for the output. The default response to the RUN ON DEVICE prompt is the device at which you are working, so the number of your device is displayed within carets. If you wish the report to run on another device, enter the number of the device, or press RETURN to accept the default response. NOHIMS will respond with the location name in parentheses. The RUN THIS JOB NOW prompt allows you to tell the system whether you want the job to run now or at a later time and/or date. Since we want the report to run at 5:30 PM on 8/23/85, we will enter N for No.

START AFTER COMPLETION OF ANOTHER JOB <N>

NOHIMS then asks if the report should be started after the completion of another job. As we have a specific run time, we enter N for No.

STARTING DATE> T (8/23/85)
STARTING TIME> 5:30P (5:30 P)
NEW JOB NUMBER 1 QUEUED

COSTAR REPORT GENERATOR OPTION >

This STARTING DATE prompt is to indicate the date on which we want the report to run. We used the T convention to indicate 8/23/85 (today), and then entered 5:30P at the STARTING TIME prompt. NOHIMS responded with the message that new job number 1 had been queued and returned us to the COSTAR REPORT GENERATOR OPTION prompt.

To run the next report, ACTIVITY6260, we would enter the same answers to the prompts up to the START AFTER COMPLETION OF ANOTHER JOB prompt. Since we want this report to run after the first report we queued is finished, we enter Y for Yes at this prompt as shown below.

COSTAR REPORT GENERATOR OPTION > RUN/RESTART REPORT

**RUN/RESTART REPORT

REPORT NAME > ACTIVITY6260 - 12/31/84 BLESSING, KATHRYN E
TAB OF ACTIVITY (DUTY STATION) FOR ENCOUNTERS
STARTING DATE > 7/1 (7/1/85)
ENDING DATE > 7/31
DOUBLE SPACE REPORT <N>
USE VISIT ORDER INDEX FOR FAST REPORT <N> Y
RUN ON DEVICE <69> (SYSGEN 69)
RUN THIS JOB NOW <Y> N
START AFTER COMPLETION OF ANOTHER JOB <N> Y

NOHIMS will then respond with the instruction to SPECIFY WHICH JOB THIS ONE IS TO FOLLOW along with the JOB NUMBER prompt. Notice that we can obtain a list of the jobs that have been queued by entering an ^L at the JOB NUMBER prompt. We selected Job Number 1 and NOHIMS indicated that ACTIVITY6260 had been queued as Job Number 2 to follow Job Number 1 and then returned us to the COSTAR REPORT GENERATOR OPTION prompt.

SPECIFY WHICH JOB THIS ONE IS TO FOLLOW

JOB NUMBER>

ENTER A JOB NUMBER OR ^L FOR A LIST OF JOBS

JOB NUMBER> ^L

1 CRG : TYPE6260C CREATED:

QUEUED AT BY BLESSING, KATHRYN E

JOB NUMBER> 1

CRG : TYPE6260C CREATED:

QUEUED AT BY BLESSING, KATHRYN E

NEW JOB NUMBER 2 TO FOLLOW JOB #1

COSTAR REPORT GENERATOR OPTION >

DATA COLLECTION FORMS/JOB AIDS

The following is a list of the data collection forms/job aids that are included in this manual showing the NOHIMS internal codes corresponding to each data item on the forms/job aids.

Patient Registration

Physical Exam Data Sheet (PEDS)

Physical Examination Findings (PEX)

Periodic Health Evaluation--Navy Asbestos Medical
Surveillance Program form (NAVMED 6260/5)

Audiology forms (DD 2215 and DD 2216)

Job Aids containing additional hazard surveillances,
hobby hazards, laboratory tests, radiology,
problem codes, and ICD-9-CM diagnoses.

OCCUPATIONAL HEALTH CARE
PATIENT REGISTRATION FORM

THIS PAGE TO BE COMPLETED BY THE PATIENT. RESPOND TO ALL ITEMS. PLEASE PRINT.

PATIENT NAME ACAB3

LAST NAME _____ FIRST NAME _____ M.I. _____

SEX ACALI

☐ (M) Male ☐ (F) Female

DATE OF BIRTH ACAT2

MONTH _____ DAY _____ YEAR _____

PERSON TO NOTIFY IN EMERGENCY (Optional)

Name: ACBX5

LAST NAME _____

FIRST NAME _____

M.I. _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Telephone Number: ARBX6 / _____

TODAY'S DATE (Date of Registration)

MONTH _____ DAY _____ YEAR _____

AARX9

SOCIAL SECURITY NUMBER (SSN)

ACARS

DUTY STATION OR ACTIVITY

ASAM5

☐ (0) Naval Supply Center

☐ (4) Public Works Center

☐ (1) Naval Air Rework Facility

☐ (5) Special Services

☐ (2) Naval Air Station N. I.

☐ (6) Navy Exchange

☐ (3) Naval Amphibious Base

☐ (7) Other (Specify) _____

PRIMARY CLINIC

ARAG8

☐ (1) North Island

☐ (4) Balboa

☐ (2) 32nd Street

☐ (5) Miramar

☐ (3) NOSC

☐ (6) Other _____

NHRC [09-30-85]

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAM DATA SHEET ENCOUNTER FORM**

P E D S

THIS PAGE TO BE COMPLETED BY THE PATIENT. RESPOND TO ALL ITEMS. PLEASE PRINT.

PATIENT NAME

LAST NAME _____ FIRST NAME _____ M.I. _____

SEX

☐ (M) Male ☐ (F) Female

DATE OF BIRTH

MONTH - DAY - YEAR

PROVIDER NO. 1 (OFFICE USE ONLY)

LAST NAME

TODAY'S DATE

MONTH - DAY - YEAR

SOCIAL SECURITY NUMBER

_____ - _____ - _____

PROVIDER NO. 2 (OFFICE USE ONLY)

LAST NAME

SITE OF ENCOUNTER

(A) North Island

AAAXØ

TYPE OF EXAMINATION Check only one.

☐ (A) Pre-placement

AAEXØ

☐ (H) Termination

☐ (B) Return to Work

☐ (I) Completion of Previous Visit
(Specify Date) MM - DD - YY

☐ (C) Fitness for Duty

☐ (D) Competence for Duty

☐ (J) Injury

☐ (E) Disability Retirement

☐ (K) Illness

☐ (F) Periodic Exam (Includes Annual Phys.)

☐ (O) Other (Specify) _____

☐ (G) Protective Equipment Only

VISIT CLASSIFICATION Check only one.

☐ (1) Civilian Scheduled Physical Exam

☐ (2) Military Scheduled Physical Exam

☐ (3) Civilian Unscheduled Physical Exam

☐ (4) Military Unsched. Physical Exam

WORK INFORMATION

JT Job Title ASAC7

BLDG Building Number ASBK4

WS Work Supervisor

ASBml

SHN Shop Number ASAK8

LAST

FIRST

SHT Shop Tel. ASØC3

*****PATIENT: PLEASE STOP HERE. REST OF FORM IS FOR OFFICE USE ONLY*****

NHRC [11-30-84]

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAM DATA SHEET ENCOUNTER FORM**

P E D S

JOB CERTIFICATION Check one *ONLY* if exam is for official job certification. (JC-)

- | | | |
|---|--|-------|
| <input type="checkbox"/> (A) Fireman/Firefighter | <input type="checkbox"/> (G) Aircraft Handler | BDAKI |
| <input type="checkbox"/> (B) Security Guard | <input type="checkbox"/> (H) Food Handler | |
| <input type="checkbox"/> (C) Diver | <input type="checkbox"/> (I) Otto Fuel Worker | |
| <input type="checkbox"/> (D) Motor Vehicle Operator | <input type="checkbox"/> (J) Corrosion Control/Painter | |
| <input type="checkbox"/> (E) Crane/Construction Operator/Rigger | <input type="checkbox"/> (O*) Other (Specify) _____ | |
| <input type="checkbox"/> (F) Explosive Handler | | |

HAZARDOUS AGENT SURVEILLANCE Check *ALL* that apply.

- | | |
|---|---|
| <input type="checkbox"/> ABD Abrasive Dust BBCE2 | <input type="checkbox"/> MC Methylene Chloride BBEV6 |
| <input type="checkbox"/> ACT Acetone BBDX7 | <input type="checkbox"/> MCA MOCA BBAV6 |
| <input type="checkbox"/> ALM Aluminum BBEG1 | <input type="checkbox"/> MLY Molybdenum Soluble BBCE7 |
| <input type="checkbox"/> ASE Asbestos BBAQ5 | <input type="checkbox"/> NCK Nickel (inorganic) BBDS2 |
| <input type="checkbox"/> BNZ Benzene BBBB9 | <input type="checkbox"/> TNT 2-Nitropropane BBDE5 |
| <input type="checkbox"/> BRY Beryllium BBCE8 | <input type="checkbox"/> NS Noise BBBF3 |
| <input type="checkbox"/> CDM Cadmium BBDR3 | <input type="checkbox"/> NR Non-ionizing Radiation BBBL7 |
| <input type="checkbox"/> CHL Chlorinated Hydrocarbons BBEN4 | <input type="checkbox"/> ORG Organotin BBCE7 |
| <input type="checkbox"/> CHR Chromium BBBY2 | <input type="checkbox"/> PST Pesticides BBAW9 |
| <input type="checkbox"/> CB Cobalt BBEP2 | <input type="checkbox"/> PHB Phenylbetanaphthylamine BBCE9 |
| <input type="checkbox"/> DXN Dioxane BBEX3 | <input type="checkbox"/> PB Polychlorinated Biphenyls (PCBs) BBDE |
| <input type="checkbox"/> ETD Ethylene Dichloride BBFM1 | <input type="checkbox"/> TRP Tar Products BBCT4 |
| <input type="checkbox"/> IHZ Eye Hazards BBBT8 | <input type="checkbox"/> THS Thermal Stress BBDE8 |
| <input type="checkbox"/> HDZ Hydrazine BBCE6 | <input type="checkbox"/> TL Toluene BBEX8 |
| <input type="checkbox"/> IR Ionizing Radiation BBDE4 | <input type="checkbox"/> THN Trichloroethane BBBD6 |
| <input type="checkbox"/> IOF Iron Oxide Fume BBEE4 | <input type="checkbox"/> THY Trichloroethylene BBBW5 |
| <input type="checkbox"/> ISC Isocyanates (Polyurethane) BBDX7 | <input type="checkbox"/> VT Vibrating Tool BBCEW1 |
| <input type="checkbox"/> ISA Isopropyl Alcohol BBEM5 | <input type="checkbox"/> VCH Vinyl Chloride BBCE5 |
| <input type="checkbox"/> LD Lead (inorganic) BBAF7 | <input type="checkbox"/> XY Xylene BBES9 |
| <input type="checkbox"/> MRC Mercury (inorganic) BBAN8 | <input type="checkbox"/> HSO Other (Specify) _____ |
| <input type="checkbox"/> MEK Methyl Ethyl Ketone (Butanone) BBDM9 | BBDP6 + ph aid codes |

NHRC [11-30-84]

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAM DATA SHEET ENCOUNTER FORM**

P E D S

PROTECTIVE EQUIPMENT Check ALL that apply.

- ☐ RSP Respirator Fit/Program Applicant BBAS2
- ☐ HRG Hearing Protection Fit BBAA3
- ☐ OPF Other Protective Equipment Issued BBAH4
(Specify) _____

LABORATORY TESTS Check ALL that apply.

- | | |
|---|---|
| <input type="checkbox"/> SMCB SMAC (Liver, Kidney, Blood Chemistry) WRFV4 | <input type="checkbox"/> HB Hemoglobin (CBC not done) MNBY1 |
| <input type="checkbox"/> UA Urinalysis WNBQ1 | <input type="checkbox"/> HCT Hematocrit (CBC not done) MNBN3 |
| <input type="checkbox"/> CBC Complete Blood Count MNAA2 | <input type="checkbox"/> CMQ Carbon Monoxide, Quantitative HQCE1 |
| <input type="checkbox"/> DFF Differential Count WRDR5 | <input type="checkbox"/> Culture and Sensitivity (Specify Source) PNAX1 |
| <input type="checkbox"/> HMC Heavy Metal Urine Copper JNAB3 | <input type="checkbox"/> HMD Heavy Metal Urine Cadmium JNAG7 |
| <input type="checkbox"/> HMB Heavy Metal Urine Beryllium JNAP8 | <input type="checkbox"/> HMA Heavy Metal Urine Arsenic JNAX9 |
| <input type="checkbox"/> HMM Heavy Metal Urine Mercury (inorg.) JNBP4 | <input type="checkbox"/> HML Heavy Metal Urine Lead (organic) JNBX1 |
| <input type="checkbox"/> HMSC Heavy Metal Serum Copper LPAB2 | <input type="checkbox"/> HMSZ Heavy Metal Serum Zinc LPAT1 |
| <input type="checkbox"/> BLD Blood Lead (inorganic) HNLN1 | <input type="checkbox"/> Other Heavy Metal (Specify) _____ |
| <input type="checkbox"/> Other Chemistry (Specify) _____ | <input type="checkbox"/> Other Chemistry (Specify) see job aids |
| <input type="checkbox"/> Other Lab Test (Specify) _____ | <input type="checkbox"/> Other Lab Test (Specify) _____ |

RADIOLOGY Check ALL that apply.

- | | |
|--|--|
| <input type="checkbox"/> CPL Chest Xray PA & Lateral SNAT3 | <input type="checkbox"/> CSB Chest Xray Asbestos SNAD1 |
| <input type="checkbox"/> CBQ Chest Xray Oblique SNAL2 | <input type="checkbox"/> Other Xray (Specify) see job aids |

PULMONARY FUNCTION TESTS Check only one.

- | | |
|---|--|
| <input type="checkbox"/> PFTA Pulmonary Function Testing for Asbestos WRFT1 | <input type="checkbox"/> PFTO Pulmonary Function Testing for Other Than Asbestos WQAZ2 |
|---|--|

ELECTROCARDIOGRAMS

- ☐ EKG Electrocardiogram WPAN1

AUDIOMETRY (Reason for Exam) Check only one.

- ☐ ENX Excessive Noise Exposure (Hearing Conservation Program) WRGK2
- ☐ AOT Other Administrative Reason (Pre-placement, Return-to-Work, Disability, Retirement, Termination, Transfer, etc.) WRGS3
- ☐ ECM Employee Complaint Only WRGA4

EYE EXAMINATION --- OPTOMETRY DEPARTMENT

- ☐ To Be Done

OCCUPATIONAL HEALTH CARE PHYSICAL EXAMINATION FINDINGS

P E X

SOCIAL SECURITY NUMBER _____

PROVIDER (PHYSICIAN ONLY) _____

LAST NAME _____

PHYSICIAN EXAMINATION Check only one. BFAYI

☐ FPE Full Physician Exam
 (Form 78 or equivalent)

☐ LPE Limited Physician Exam (such as
Respirator, Asbestos, Competence
for Duty, and other partial exams)

☐ OEPE Omitted Entire Physician Exam

☐ RPE Refused Entire Physician Exam

HT Height _____ inches CAJCI

WT Weight _____ lbs. CAKHI

VITAL SIGNS

TMP (Temperature) CACVI

PLS (Pulse) CADA1

RR (Respiratory Rate) CAFLI

BP (Blood Pressure) CAEFI

GENERAL APPEARANCE Check: CBAMI
(GAX-)

If entire exam.....(N)ORMAL ☐

If any ABNORMALITIES, describe:
(A/GAB) CBAC3

SKIN

Check:
(SKX-) GBAWI

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/SKB-) GBADA2

- ☐ (F)ace or Neck ☐ (A)bdomen
☐ (U)pper Extrem. ☐ (G)roin or Buttocks
☐ (B)ack or Shldr ☐ (L)ower Extrem.
☐ (C)hest or Axil. ☐ (O*)ther, specify: _____

Concise Comments(*): _____

EYES

Check:
(EYX-) HBAJ9

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/EYB-) HBAJ1

- ☐ (P)upils ☐ (E)OM
☐ (C*)onjunctiva/Eyelids ☐ Rt ☐ Lt ☐ Bot
☐ (S*)clera/Cornea/Iris ☐ Rt ☐ Lt ☐ Bot
☐ (F*)undusopic ☐ Rt ☐ Lt ☐ Bot
☐ (O*)ther, specify: _____

Concise Comments(*): _____

EARS

Check:
(ERX-) JBAA1

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/EXB-) JBAY4

- ☐ (E*)xternal Ear ☐ Rt ☐ Lt ☐ Bot
☐ (C*)anals, External ☐ Rt ☐ Lt ☐ Bot
☐ (T*)ympani ☐ Rt ☐ Lt ☐ Bot
☐ (O*)ther, specify: _____

Concise Comments(*): _____

OCCUPATIONAL HEALTH CARE PHYSICAL EXAMINATION FINDINGS

P E X

NOSE Check: JBAH2
(NX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/NB-) JBAF5

☐ (E)xternal ☐ (O*)ther, specify:

☐ (M)ucosa

Concise Comments(*):

ORAL CAVITY Check: JBAQ3
(MX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/MB-) JBAN6

☐ (L)ips ☐ (P)harynx

☐ (G)ums or Teeth ☐ P(a)late

☐ (M)outh ☐ (O*)ther, specify:

☐ (B)reath

☐ (T)ongue Concise Comments(*):

NECK Check: VBA X1
(NKX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/NKB-) VBAV4

☐ (M)uscles ☐ T(r)achea

☐ (S)pine ☐ (C)arotid Arteries

☐ (T)hyroid ☐ (O*)ther, specify:

☐ (L)ymph Nodes

Concise Comments(*):

THORAX AND LUNGS Check: LBAE1
(TLX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/TLB-) LBAM2

☐ (T)horacic Wall (masses, pain, tenderness, crepitus or other)

☐ (R)ales (Crackles) ☐ (O*)ther, specify:

☐ (W)heezes

Concise Comments(*):

FEMALE BREAST Check: PBAL1
(BRX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, describe:
(A/BRB) PBAB3

HEART Check: MBA61
(HX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/HXB-)

☐ (M)urmur(s) ☐ (P)alpation (Thrill)

☐ (R)hythm ☐ (O*)ther, specify:

☐ (H)eart Sounds MBAP2

Concise Comments(*):

AXILLAE Check: PBAT2
(AXL-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, describe: (A/AXB)

00AT4

OCCUPATIONAL HEALTH CARE PHYSICAL EXAMINATION FINDINGS

P E X

ABDOMEN Check: QBAN1
(ABX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/ABB-) QBAD3

- ☐ B(r)uits ☐ (B)owel Sounds
☐ (M)ass ☐ (T)enderness
☐ (L)iver ☐ (O*)ther, specify:
☐ (S)pleen

Concise Comments(*):

FEMALE GENITALS Check: RBAQ1
(FGX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/FGB-) RBAy2

- ☐ (E)xternal Genitalia ☐ (H)ernia
☐ (S)peculum Exam ☐ (O*)ther, specify:
☐ (P)alpation

Concise Comments(*):

MALE GENITALS Check: SBASI
(MGX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/MGB-) SBAA2

- ☐ (P)enis ☐ (H)ernia
☐ (T)esticles ☐ (O*)ther, specify:

Concise Comments(*):

RECTAL Check: QBAW2
(REX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/REB-) QBAL4

- ☐ (A)nus ☐ (H)emoccult Positive
☐ (M)ass ☐ (O*)ther, specify:
☐ (P)rostate

Concise Comments(*):

BACK Check: VBAE2
(BX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/BB-) VBAC5

- ☐ (S)pine Palpation ☐ (O*)ther, specify:
☐ (R)ange of Motion

Concise Comments(*):

EXTREMITIES AND JOINTS Check:
(EJX-) VBAM3

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/EJB-) VBAK6

- ☐ (H)and ☐ (S)houlder ☐ (L)ower Leg
☐ Fi(n)gers ☐ H(I)p ☐ (A)nkle
☐ (W)rist ☐ Thi(g)h ☐ (F)oot
☐ Fo(r)earm ☐ (K)nee ☐ (T)oes
☐ (E)lbow ☐ (O*)ther, specify:

Concise Comments(*):

OCCUPATIONAL HEALTH CARE PHYSICAL EXAMINATION FINDINGS

P E X

NEUROPSYCHIATRIC Check: WBAZI (NPX-)

If entire exam.....(N)ORMAL ☒

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/NPB-) WBAG2

- ☐ (M)ental Status ☐ (R)omberg
- ☐ Cranial (N)erves ☐ (B*)ehavior, specify: _____
- ☐ (C)oordination _____
- ☐ (G)en Motor Response _____
- ☐ (D)eep Tendon Reflexes _____
- ☐ (S)ensory Testing Gen. _____
- ☐ (O*)ther, specify: _____

Concise Comments(*): _____

OTHER FINDINGS (OTX)

CDAV2

Concise Comments: _____

VASCULAR SYSTEM Check: NBAJI (VX-)

If entire exam.....(N)ORMAL ☐

If entire exam ☐ (O)mitted ☐ (R)efused

If any ABNORMALITIES, specify where:
(A/VB-) NBAR2

- ☐ (C)arotid Pulses
- ☐ (B)rachial Pulses
- ☐ (R)adial Pulses
- ☐ (A)bdominal Aorta Pulses
- ☐ (F)emoral Pulses
- ☐ (P)opliteal Pulses
- ☐ (D)orsalis Pedis Pulses
- ☐ Posterior (T)ibial Pulses
- ☐ (V)aricosities
- ☐ (O*)ther, specify: _____

Concise Comments(*): _____

***** PROBLEM LIST

If appropriate, indicate special status with a letter before the slash.

- ☐ NO PROBLEMS (I = Inactive, H = History of, R = Rule Out, P = Presumptive,
Y = Status Post, M = Major, S = Short Duration)

(ICD-9-CM)

____/____	()
____/____	()
____/____	()
____/____	()
____/____	()
____/____	()
____/____	()
____/____	()
____/____	()
____/____	()

**OCCUPATIONAL HEALTH CARE
PHYSICAL EXAMINATION FINDINGS**

P E X

DISPOSITION Check ALL that apply. (DSP-)

- ☐ (A) Full work/duty
- ☐ (B) Send home/sick in quarters
- ☐ (C) Admit to hospital

AACQ1

☐ **RESTRICTION(S)** (If restricted, check ALL that apply.)

- ☐ (D) Lifting, pushing, pulling or carrying
- ☐ (E) Climbing, working at heights, driving gov't vehicle or working around dangerous machinery
- ☐ (F) Noise or vibration
- ☐ (G) Bending, twisting or awkward positions
- ☐ (H) Dust, fumes, smoke or gases
- ☐ (I) Walking, standing or foot hazardous areas
- ☐ (J) Crawling, kneeling or squatting
- ☐ (K) Chemicals, solvents, greases, oils
- ☐ (L) Other Restriction (Specify) _____

☐ **REFERRAL** If the patient is referred to a specialty clinic, ER or private doctor, check the appropriate box(es) below.

TYPE OF REFERRAL	CLINICS					
	Ophthalmology	Emer. Room	Cast Room/Orthopedics	Dermatology	Otolar./Audiol.	Other (Specify)
Refer to NAVHOSPSANDIEGO the same day	(M)	(N)	(O)	(P)	(Q)	(R)
Refer to NAVHOSPSANDIEGO another day	(S)	(T)	(U)	(V)	(W)	(X)
Refer to civilian medical facility the same day	(Y)	(Z)	(Ø)	(1)	(2)	(3)
Refer to civilian medical facility another day	(4)	(5)	(6)	(7)	(8)	(9)

NHRC [11-30-84]

PERIODIC HEALTH EVALUATION

NAVY ASBESTOS MEDICAL SURVEILLANCE PROGRAM

Sections 133, 1071.87, 3012, 5031 and 8012, Title 10 USC & Exec. Order 9397 (Privacy Act of 1974) Apply
USE HARD TIPPED PEN & PRESS FIRMLY. LEGIBLE COPY REQUIRED FOR DATA ENTRY

TYPE EQUALS 5 (ASBESTOS SURVEILLANCE)

RETAIN ORIGINAL IN HEALTH RECORD SEND COPY TO Commanding Officer NAVY ENVIRONMENTAL HEALTH CENTER Naval Station, Norfolk, Virginia 23511		EXAMINATION FACILITY NAME UIC <input type="text"/>		PAGE 1 of 1 CONTROL NUMBER (For NEHC Use Only)	
NAME (LAST) (FIRST) (M.I.) <u>GREELEY, JAMES C</u>		SOCIAL SECURITY NO. <u>061-32-7684</u>			
DATE OF BIRTH (DAY) (MO) (YR) <u>07</u> <u>14</u> <u>50</u>		RACE (Check One) <input type="checkbox"/> White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian <input type="checkbox"/> Other		STATUS (Check One) <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input checked="" type="checkbox"/> Civilian	
SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		YRS. GOV'T. SER. <u>13</u>		OCCUPATIONAL CODE (Civilian Employees) <input type="text"/>	
TODAY'S DATE (DAY) (MO) (YR) <u>09</u> <u>26</u> <u>84</u>		EXAM PURPOSE (Check One) <input type="checkbox"/> INITIAL ABAD7 <input checked="" type="checkbox"/> PERIODIC ABAL8 <input type="checkbox"/> TERMINATION ABAT9		SHIPBOARD PERS. ONLY ENTER SHIP HULL NO. <input type="text"/>	
RESPIRATORY QUESTIONNAIRE					
1. Are you currently working directly with asbestos in your job? (within the last year) <u>UET6</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
2. A. Was/is your exposure on a regular basis? (15 days per quarter or 45 days per year) <u>UEB7</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
B. How many years? (check one) Less than one <input type="checkbox"/> More than one; less than five <u>UEJ8</u> <input checked="" type="checkbox"/> More than five; less than fifteen <input type="checkbox"/> More than fifteen <input type="checkbox"/>					
C. How old were you when first exposed? <u>LLER9</u> <u>22</u> YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. Do you usually have or have you usually had the following? (Usually means more than a quarter of the time.) A. Cough <u>LLFL1</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> B. Phlegm <u>LLFT2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> C. Wheezing <u>LLFB3</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> D. Shortness of breath <u>LLFJ4</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
4. Do you now or have you ever smoked cigarettes? (If no, skip to question 5.) <u>LLFR5</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> A. If so, what age did you begin? <u>LLFZ6</u> <u>15</u> B. How much do you/did you smoke? (on average) <u>LLFG7</u> Less than one pack per day <input type="checkbox"/> One pack per day <input checked="" type="checkbox"/> More than one pack per day <input type="checkbox"/> More than two packs per day <input type="checkbox"/> C. If you have quit, at what age did you do so? <u>LLFP8</u> <input type="text"/>					
5. Do you smoke a pipe or cigars? (If no, skip to question 6.) <u>LLFX9</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> A. How many years have/did you smoke a pipe or cigars? <u>LLGR1</u> <input type="text"/>					
6. Have you ever had a serious lung disease requiring hospitalization? <u>LLGZ2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
RESPIRATORY PHYSICAL EXAMINATION					
7. Weight (in pounds) <u>CAKH1</u> <u>215</u> Height (in inches) <u>CAJCI</u> <u>69</u>					
8. Appearance A. Stature Normal <u>LBAV3</u> <input checked="" type="checkbox"/> Obese <input type="checkbox"/> B. Chest Configuration Normal <input checked="" type="checkbox"/> Increased A-P diameter <u>LBAC4</u> <input type="checkbox"/> Other chest deformity <input type="checkbox"/> C. Clubbing None <u>LBAK5</u> <input checked="" type="checkbox"/> Present <input type="checkbox"/>					
9. Crackles <u>LBAS6</u> None <input type="checkbox"/> Localized late inspiratory <input type="checkbox"/> Bilateral late inspiratory <input type="checkbox"/> Localized early inspiratory <input checked="" type="checkbox"/> Bilateral early inspiratory <input type="checkbox"/>					
10. Wheezes <u>LBAA7</u> None <input checked="" type="checkbox"/> Single or multiple monophonic wheezes <input type="checkbox"/> Polyphonic expiratory wheezes <input type="checkbox"/> Short late inspiratory, monophonic wheeze associated with inspiratory crackles <input type="checkbox"/>					
11. Spirometry (note decimal point) WQAP4 FVC observed (BTPS) in liters <u>3.42</u> WQAE6 FEV1 observed (BTPS) in liters <u>3.15</u>					

NOHIMS JOB AID

LABORATORY TESTS

HMA	Heavy Metal Test for Urine Arsenic	JNAX 9
HMB	Heavy Metal Test for Urine Beryllium	JNAP 8
HMD	Heavy Metal Test for Urine Cadmium	JNAG 7
HMCH	Heavy Metal Test for Urine Chromium	JNAR 5
HMC	Heavy Metal Test for Urine Copper	JNAB 3
HMI	Heavy Metal Test for Urine Iron	JNAL 1
HML	Heavy Metal Test for Urine Lead (organic)	JNBX 5
HMG	Heavy Metal Test for Urine Manganese	JNAJ 4
HMM	Heavy Metal Test for Urine Mercury (Inorganic)	JNBP 4
HMN	Heavy Metal Test for Urine Nickel	JNAZ 6
HMZ	Heavy Metal Test for Urine Zinc	JNAT 2
HMSC	Heavy Metal Test for Serum Copper	LPAB 2
HMSM	Heavy Metal Test for Serum Manganese	LP AJ 3
HMSZ	Heavy Metal Test for Serum Zinc	LPAT 1

SMCB	SMAC for Liver, Kidney and/or Blood Chemistry Profile WRFV 4	
GLUCOSE	CNEC2	GLUCOSE SERUM FASTING
NA	CNBD1	SODIUM
K	CNBL2	POTASSIUM
CL	CNBT3	CHLORIDES SERUM
CO2	CNBG8	CARBON DIOXIDE SERUM
CR	CNCP5	CREATININE BLOOD
BUN	CNCZ3	BLOOD UREA NITROGEN
UA	CNPT1	URIC ACID BLOOD
CA	CNFA1	CALCIUM
P	CNAF2	INORGANIC PHOSPHATE PO4
TB	CNKX1	BILIRUBIN TOTAL
DB	CNKE2	BILIRUBIN DIRECT
TP	EPBL1	TOTAL SERUM PROTEINS
ALB	EPCR1	ALBUMIN
ALP	ENPF2	FRACTIONATED ALKALINE PHOSPHATASE
ALT(SGPT)	ENBN5	SERUM GLUTAMIC PYRUVIC TRANSAMINASE
SGOT(AST)	ENBH1	SERUM GLUTAMIC OXALOACETIC TRANSAMINASE
LD	ENGA3	LDH ISOENZYMES
CK	ENHF3	CREATINE PHOSPHOKINASE ISOENZYMES
CHOL	CPCM1	CHOLESTEROL BLOOD
TRIG	CPCS5	TRIGLYCERIDES

NOHIMS JOB AID

LABORATORY TESTS

CBC	Complete Blood Count	MNAA2
	MNBD5	RED BLOOD CELL COUNT
	MNBY1	HEMOGLOBIN
	MNBN3	HEMATOCRIT
	MNBW4	MEAN CORPUSCULAR VOLUME
	MNDJ1	WHITE BLOOD CELL COUNT
MCH	MNBL6	MEAN CORPUSCULAR HEMOGLOBIN MNBL6
MCHC	MNBT7	MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATE MNBT1

DFF	Differential with Morphology	WRDR5
	MNDZ3	DIFFERENTIAL COUNT
	MNAY5	PLATELETS
	MNAQ4	RBC MORPHOLOGY

VDRL	VDRL	RNGZ3
------	------	-------

RADIOLOGY

CSP	Cervical Spine Xray	SPRJ1
CPL	Chest Xray - PA & Lateral	SNAT3
CBQ	Chest Xray - Oblique	SNAL2
CSB	Chest Xray - Asbestos	SNAD1
LSP	Lumbosacral Spine Xray	SPRD3
RBS	Ribs Xray	SPQH1
SKL	Skull Xray	SPCS1
UXX	Upper Extremities Xray	SQAK1
LXX	Lower Extremities Xray	SQHY1

JUNE 1980

OVERVIEW OF THE COSTAR MAILBOX

The COSTAR Mailbox Module provides the capability for users of the system to send messages to each other. System managers may also send messages of general interest to all users on the system. If a message has been sent to you, you will be notified when you log onto the system. Manager's messages display automatically following your ID acknowledgment. If you have a message from another COSTAR user, you will get a notification ("YOU HAVE MAIL") at your ID acknowledgment. In this case you will need to enter the MAILBOX function to print your messages.

The Mailbox Module has three options:

SEND MAIL
PRINT MAIL
DELETE MAIL

The function of each option is indicated by its name. The system will prompt you for the necessary information to perform each function within the options.

GETTING STARTED WITH THE COSTAR MAILBOX

When COSTAR prompts you for the SYSTEM OPTION, respond with MAILBOX to enter the module. The system will then ask you which MAILBOX OPTION you wish to use. Use the "?" command to display the available options.

SYSTEM OPTION > MAILBOX

MAILBOX OPTION > ?

ENTER ENOUGH CHARACTERS TO IDENTIFY ONE OF THE FOLLOWING:

SEND MAIL
PRINT MAIL
DELETE MAIL

SENDING A MESSAGE

MAILBOX OPTION > SEND MAIL

If you are a system manager, the next prompt will ask if you would like to send a "manager's message" which will be displayed to all users. The default for this prompt is "NO", so you will have to override it with "YES" to send a manager's message. COSTAR will then provide prompts for entering your message. When you hit the return key at the beginning of a line, COSTAR will assume the message is complete.

MAILBOX OPTION > SEND MAIL

SEND MANAGER'S MESSAGE? < N > Y

ENTER MANAGER'S MESSAGE:

1 > HELLO USERS,
2 > PLEASE LEARN TO USE THE
3 > MAILBOX OPTION TODAY.
4 > —

At this point the system displays the message so you can check its content.

JUNE 1980

MANAGER'S MESSAGE

HELLO USERS,
PLEASE LEARN TO USE THE
MAILBOX OPTION TODAY.

FILE, EDIT OR IGNORE? FILE

After filing, the message will be sent to all users automatically when they log on. The message will be displayed at every log-on until it is deleted by a system manager.

After filing a manager's message, the system will prompt for another. You may enter as many manager's messages as you wish. When you have entered the last message, hit the return key.

ENTER MANAGER'S MESSAGE:

1 > _

MAILBOX OPTION > _

There
is no other
manager's message, so
the manager nulls out
of the function.

If you want to send an individual message, enter "SEND" at MAILBOX OPTION and then null through until the system prompts for ADDRESSEE. Then proceed as described below.

If you are not a system manager, you will be asked for an addressee following your SEND command. Only enough letters of the person's name to identify the addressee are necessary. You will next be prompted for your message. Enter your message as described above. When you have finished, the message will be displayed and you can choose to file, edit, or ignore it.

MAILBOX OPTION > SEND MAIL

ADDRESSEE > SM.J

SMITH,JOHN L; PROGRAMMER

JUNE 1980

ENTER MESSAGE:

```
1 > HELLO JOHN,
2 > HERE I AM LEARNING TO USE THE MAILBOX.
3 > JANE
4 > —
```

MAIL FOR SMITH, JOHN L

```
HELLO JOHN,
  HERE I AM LEARNING TO USE THE MAILBOX.
JANE
```

Editing a Message

Suppose when the message is displayed after you've entered it, you find you have made an error or wish to change it. Then, when the system prompts to file, edit, or ignore, just enter "edit". You will be prompted for an edit command. Enter a "?" to get an explanation of the edit commands.

FILE, EDIT, OR IGNORE? EDIT

EDIT COMMAND ?

ENTER THE FIRST CHARACTERS OF AN EDIT COMMAND, A SPACE, AND A LINE NUMBER OR LINE RANGE, E.G.,

WRITE	W 5	WRITE LINE 5
	W 3:7	WRITE LINES 3 THROUGH 7
INSERT	IN 3	INSERT NEW LINES STARTING WITH LINE 3 (RANGE IS NOT ALLOWED)
DELETE	D 2:5	DELETE LINES 2 THROUGH 5
RETYPE	R 4:6	RETYPE LINES 4 THROUGH 6 SAME AS 'D 4:6' FOLLOWED BY 'I 4'
EDIT	E 3	EDIT LINE 3

ENTER NO LINE NUMBER TO SPECIFY THE FIRST AND/OR LAST LINES:

R 4:	RETYPE LINES 4 THROUGH THE END
W :	WRITE ALL LINES

OR ENTER 'NULL' TO EXIT

JUNE 1980

Suppose you want to insert a line in the message you just entered. Here is the original message:

MAIL FOR SMITH,JOHN L

HELLO JOHN,
HERE I AM LEARNING TO USE THE MAILBOX.
JANE

FILE, EDIT, OR IGNORE? EDIT

EDIT COMMAND > I 3

3 > ENOUGH FOR NOW.

4 > —

EDIT COMMAND > —

MAIL FOR SMITH, JOHN L

HELLO JOHN,
HERE I AM LEARNING TO USE THE MAILBOX.
ENOUGH FOR NOW.
JANE

Now suppose you want to add the word "COSTAR" in the second line.

FILE, EDIT, OR IGNORE? EDIT

See
commands on
page 7

EDIT COMMAND > E 2
REPLACE

COSTAR
responds with
REPLACE and waits for
you to enter the seg-
ment of the line you
with to correct

REPLACE THE MAILBOX WITH

COSTAR responds
with WITH and
waits for your
correction

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So you have:

REPLACE THE MAILBOX WITH THE COSTAR MAILBOX

and COSTAR displays:

HERE I AM LEARNING TO USE THE COSTAR MAILBOX.

REPLACE (It asks for any further edits to the second line.)

EDIT COMMAND > _

Since there are no more edit commands given, the system displays the message:

MAIL FOR SMITH, JOHN L

HELLO JOHN,

HERE I AM LEARNING TO USE THE COSTAR MAILBOX.
ENOUGH FOR NOW.

JANE

FILE, EDIT, OR IGNORE? FILE

PRINTING A MESSAGE

When you log onto the system, any messages from the system manager will automatically print after you have entered your ID code.

ID CODE > _

Your ID code

GOOD MORNING JOHN

JONES, JANE D 6/05/80 10:48
PLEASE LEARN TO USE THE
MAILBOX OPTION TODAY.

The name
of the person sending
the message and
the date and time it
was sent are automatically
recorded
and printed

SYSTEM OPTION > _

If you have individual mail from anyone, you will be notified along with the acknowledgement of your ID code.

ID CODE > _

GOOD MORNING JOHN, YOU HAVE MAIL

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To see your mail, respond with MAILBOX at the SYSTEM OPTION prompt, and then with PRINT MAIL when asked for MAILBOX OPTION.

SYSTEM OPTION > MAILBOX

MAILBOX OPTION > PRINT MAIL

If you are the system manager, the next prompt will ask if you want to print the manager's messages. This prompt defaults to "NO". If you want to see what messages are currently stored in the manager's message mailbox, you can override it with a "YES". The system will either print the messages or tell you there are none.

PRINT MANAGER'S MESSAGE? < N > Y

NO MESSAGES

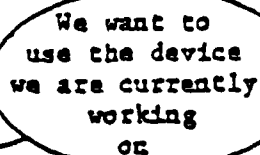
MAILBOX OPTION >

If you use the default "NO" to this question, or if you are not the system manager, the next prompt asks for the output device where you want to have your messages displayed. Enter a "?" to this prompt to see your options.

OUTPUT DEVICE > ?

ENTER THE LINE NUMBER OF THE DEVICE YOU WOULD LIKE TO USE;
ENTER NULL (HIT THE 'ESC' KEY) TO USE YOUR PRESENT DEVICE;
IF YOU DON'T KNOW THE LINE NUMBER, YOU MAY TYPE ^L TO LIST
THE DEVICES AND THE LOCATIONS, OR ENTER ENOUGH CHARACTERS
TO IDENTIFY THE DEVICE LOCATION OR NAME

OUTPUT DEVICE >



We want to
use the device
we are currently
working
on

The next question asks which message you want to print. Again enter a "?".

PRINT MESSAGE > ?

ENTER A LIST OF MESSAGES TO BE PRINTED, E.G., '2,3,6'
OR 'ALL' TO PRINT ALL MESSAGES
OR '^L' FOR A LIST OF CURRENT MESSAGES

PRINT MESSAGE > ALL

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1 JONES, JANE D 6/05/80 11:30 AM
HELLO JOHN,
HERE I AM LEARNING TO USE THE COSTAR MAILBOX.
ENOUGH FOR NOW.
JANE

PRINT MESSAGES > _

MAILBOX OPTION > _

DELETING A MESSAGE

After you have printed your messages you will probably want to delete them. You can delete all messages or just specific ones.

MAILBOX OPTION > DELETE MAIL

DELETE MESSAGES > ?

ENTER A LIST OF MESSAGES TO BE DELETED, E.G., '2,3,6'
OR 'ALL' TO DELETE ALL MESSAGES
OR '^L' FOR A LIST OF CURRENT MESSAGES

DELETE MESSAGES > ALL DELETED

The system
responds to
tell you the mes-
sages have been
deleted

If you are a system manager, COSTAR will first ask if you want to delete any manager's messages. This prompt defaults to "NO", so if you want to delete a manager's message you must enter "YES". After you have deleted those messages, the system next prompts for MAILBOX OPTION. If there are also personal messages you have received which you want to delete, you must again enter DELETE MAIL and null through the DELETE MANAGER'S MESSAGES prompt. The next prompt will ask which messages you want to delete.

MAILBOX OPTION > DELETE MAIL

DELETE MANAGER'S MESSAGES ? < N > Y

DELETE MESSAGES > ^L

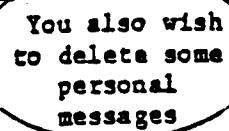
1 JONES, JANE D 6/05/80 10:48 AM

You may want
to enter '^L' to
list the current
messages, or you
may just enter
ALL

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DELETE MESSAGES > 1
1 DELETED

MAILBOX OPTION > DELETE MAIL



You also wish
to delete some
personal
messages

DELETE MANAGER'S MESSAGES ? < N > _ (Null through)

DELETE MESSAGES > ALL DELETED (Refers to personal messages)

MAILBOX OPTION > _

SYSTEM OPTION > _